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ORIGINAL ARTICLES.

REPORT OF THE COMMITTEE ON THE HEALTH PROTECTIVE HOSPITAL FOR CONTAGIOUS DISEASES.

J. MADISON TAYLOR, M.D., PHILADELPHIA.

The Woman's Health Protective Association of Philadelphia was founded in 1893, at a time when the United States was threatened with an invasion of cholera, with an initial membership of two hundred. The Association decided that it was of the first importance to obtain a thorough knowledge of municipal government, and of the problems presented in pursuing their work for the public health, and for this reason they confined their attention to study for the first winter, and invited various public officials to address them, especially those of the Board of Health and the Department of Public Works.

During the second year of the Association's existence it was decided to form committees on the various causes affecting the public health and safety, with the aim of accomplishing some practical results, and the following committees were organized: Contagious Diseases, Water Supply, Street Cleaning and Collection of Garbage and Ashes Committees, Sweating System, Trolley and Literature. Later, the Street Cleaning and Collection of Garbage and Ashes Committees were consolidated, and also the committees on the Sweating System and Visiting Public Schools. To

these have since been added Committees on Bakeshops, Playgrounds and Entertainment.

In the Contagious Diseases Committee much thought was given in 1895 to a slight epidemic of small-pox, and after some discussion, in a conference on the subject, the Association put itself on record in a strong resolution advocating vaccination, and also in resolutions praying the Board of Health to universally mark all houses containing the several contagious diseases. Considering the fact that the last epidemic of small-pox cost the city of Philadelphia twenty-one and a half million of dollars, it seems as if too strong action could not be taken by the Board of Health to stamp out the contagious diseases. To the astonishment of the Association, however, it was discovered that the Board of Health finds great difficulty in causing individual cases to be flagged or marked. There is reason to feel that by agitation and education our citizens will soon come to see the misery that recklessness in this respect causes the community on account of the many outsiders who come to Philadelphia, as well as to our own citizens. It is a matter of first im-

portance that people should not be allowed to walk unsuspectingly into a veritable death-trap. The Association has also taken active steps in regard to the contagiousness of tuberculosis.

Here it may be said that the Association at this time found itself much hampered by a lack of funds, and so it was decided to publish a Woman's Edition of the *Philadelphia Press*. This netted six thousand eight hundred dollars; forty-five hundred the share of the Health Protective Association, and twenty-three hundred to be the nucleus of a fund to start a Contagious Diseases Hospital for pay patients. A Joint Committee was formed of members of the Philadelphia County Medical Society and of the Woman's Health Protective Association, who issued a strong appeal to the public, stating the necessity for such a hospital in Philadelphia. This Committee also protested against the removal of the Municipal Hospital from its present site.

During the past year the Street Cleaning

Committee has been considered of use to the city by the Mayor and heads of departments, and hopes to increase its usefulness in the future.

The Committee has been actively engaged during the past year endeavoring to lessen in some way the habit of expectorating in public buildings, market houses and on the sidewalks. Permission has been given to place signs on the streets, with the words, "Please do not spit on the sidewalks," printed in plain letters. Believing that this habit arises from a lack of thought, the Association appeals to the public to kindly consider this suggestion. Efforts have been made to interest the Councils of the city in the matter, especially as a bill was brought up before that body forbidding expectoration in railway cars and in public buildings.

During a conference with the Committee on Fire and Health of Councils the question discussed was whether a law could be enacted against expectoration in public buildings or on the sidewalks.

THE MUNICIPAL HOSPITAL OF PHILADELPHIA.

EDWIN ROSENTHAL, M.D., PHILADELPHIA.

It must be confessed that many erroneous opinions have been formed regarding the value and the utility of the institution I wish to describe, and that many objectionable comments have from time to time been made by those who should be in a position to know better, in consequence of mere ignorance of the Hospital, of its situation, and of the work that is done; and it is this that prompts me to present this paper.

It might have been better for such a paper to have emanated from one of the physicians connected with the Hospital, or from a member of the Board of Health; but I trust it will not lose in value if one who has no connection with the institution or with the controlling body, details a short history of the events that led to the building of this Hospital, discusses its merits and defects; and whose knowledge

of its workings has been obtained by accepting the courteous invitation to visit the Hospital, an invitation that is open to all physicians.

This paper claims no originality. The facts were obtained from the "Report of the Bureau of Health," substantiated by the various histories of Philadelphia; and also from the annual report of the physician in charge, Dr. Welch.

It is recorded that up to the year 1743, there had not been an organized Hospital in the city of Philadelphia. In 1726, small-pox broke out in the city, and a house located near the intersection of Ninth and South streets was used as an isolation house. The victims of this epidemic were taken to farm-houses. In the year 1743 a movement was started by the merchants of the city to provide for the sick, on account of the increase of small-pox brought

by immigrants from Germany. The Colonial Assembly became alarmed and built a small hospital on State Island, at a later period called Fisher's Island, near the mouth of the Schuylkill river. This remained in use for sick immigrants until the year 1800, when the Lazaretto, on Little Tinicum Island in Delaware county, was organized.

The calamitous visitation in 1793 had so alarmed the inhabitants that it was considered absolutely necessary to institute measures to insure public safety. The Guardians of the Poor had already refused to receive small-pox or fever patients into the almshouse, then located on Spruce street, between Tenth and Eleventh. The Pennsylvania Hospital was closed at that time. The Guardians of the Poor took possession of the old circus at Sixth and Chestnut streets, but the residents of the neighborhood threatened to burn the place down unless the sick were removed. Application was then made to the Magistracy of the city, and finally a place was selected on Bush Hill.

The Board of Health was organized in 1794, and purchased Fish tavern, on the west side of the bridge, occupied for years by the Pennsylvania Railroad Company. This was used for a time for hospital purposes. The first hospital established by the city in 1796 or 1797, was at the foot of Race street, on the Schuylkill river, and was known as the "Wigwam" Hospital. In 1805 the citizens in the vicinity of the "Wigwam" Hospital entered complaint against the institution. It was finally removed to a spot on the Wissahickon road, near where Ridge avenue and Wallace street now intersect each other. Here it remained for two seasons only, when the citizens demanded its removal. For a time the city was again without a hospital. The people seemed to be of the opinion that if another epidemic should visit the city, buildings should be located at some distant place to meet the emergency.

In the year 1810, a hospital for infectious diseases was erected on Bush Hill, where it remained until 1855, when it was removed. From that time until 1865 the city was without a hospital for infectious diseases, and this was a matter of much regret. The Board of Health was obliged to open the Lazaretto Hospital, and pa-

tients had to be removed twelve miles from the city. No one can form an adequate idea of the amount of suffering these unfortunates were subjected to.

In 1865 the "Municipal Hospital for Contagious Diseases," at Twenty-second and Lehigh Avenue, was completed, and handed over to the Board of Health. The plot of ground contains ten acres. Part of the plot is unavailable for hospital purposes on account of being located across the street. The buildings consist of a main structure containing a central administration building and two wings, having a total length of 280 feet and a width of 50 feet. Each wing contains two wards on either floor, 42 by 26½ feet, and 14 feet in height, making eight wards in all, each ward accommodating 20 beds. In the attic are six rooms on one side, and the same space on the other, though not divided into small compartments.

The main building is 50 feet square, with a basement, two stories and an attic, and is covered with slate roof, French style. The center building has four rooms on each floor, 18 by 20 feet, with a hall 10 feet wide, containing a flight of stairs from the cellar to the attic, and a cross entry connecting with the piazzas that run the entire length of the hospital wings. The wards in each wing of each story are separated by rooms 12 feet in width, provided with baths, water-closets, etc., and from them there is access to the piazzas, which were intended to shelter convalescent patients, and furnish them the means of exercise in the open air.

The wards are heated by furnaces in the cellar and also by open grates. The supply of water and gas is now obtained from the city mains. Formerly both had to be obtained on the premises. There is a stone stable and carriage house, and a laundry and drying-room under the same roof. These constituted the buildings in 1865.

The hospital, although a great improvement over any previously possessed by the city of Philadelphia, was incomplete in many respects and not well adapted for the treatment of a variety of contagious diseases. The plumbing was defective in plan and in execution. The drainage was conducted to wells upon the premises. In 1873 the drainage was very much im-

proved by abandoning the wells and connecting the system with sewers near by. Water and gas were introduced from the city mains in the year 1890. In 1875 a chamber for disinfecting by dry heat, and one for disinfecting by chemic vapors were constructed at the north end of the laundry building. This was in use until the fall of 1893, when a steam disinfecting plant was constructed. In 1892 a cremating furnace was erected upon the grounds for the purpose of destroying infected clothing, bedding, etc., in a prompt and inoffensive manner. This furnace was constructed upon the plan of a reverberatory furnace, the smoke being consumed.

Another improvement, which is perhaps of greater importance, was the erection of a "Pavilion Hospital" in 1893. This building is located on the plot adjoining that upon which the main building stands, the plot having an area of about four acres. This building is complete in itself. It was erected with the idea that cholera would probably reach the city, and upon completion, was turned over immediately for the use of diphtheria patients. Since the fall of 1893 it has been in constant use for the treatment of this disease. Frequently it has been filled to its utmost capacity, and as diphtheria is a disease that is constantly more or less prevalent in Philadelphia, and as the application of the bacteriologic proof will necessarily detain patients for a longer period than formerly, this building, which has an extreme capacity of sixty beds, has been found inadequate to meet the demands made upon it for this class of patients alone, and a new pavilion hospital was erected and completed in 1896. This addition will be spoken of further on.

In 1895 two bath-rooms were constructed in the place of the old disinfecting chamber at the north end of the laundry. These are complete in every respect and are used for bathing by a class of patients immediately after leaving the hospital building and before leaving the institution.

There have also been constructed this year three small portable hospital buildings, similar to the one erected in 1893 as a temporary small-pox hospital. These buildings are capable of accommodating twelve patients each, but one having been

reserved for the nurse's use, the capacity is reduced to thirty-six patients. Connected with this group of buildings are two diet-kitchens, furnished with gas-stoves, two bath-rooms, and two water-closets, and a water-closet and bath-room for the nurses. A small laundry for their especial use has also been added. These buildings were to be used for small-pox patients, but are at present used for a special class of patients, such as mixed cases of scarlet fever and diphtheria.

In 1894 a lodge-house was constructed at the north-west entrance. A gate-keeper resides here, who answers questions asked by those who visit the hospital, in connection with relatives or friends therein. The information is transmitted through a telephone, communicating with the different parts of the hospital.

The most essential improvement has been made within the last three years, an addition being made last year to the diphtheria pavilion. This is similar in appearance to the other pavilions, but is vastly superior in construction, being provided with all the improvements that time and experience have shown to be necessary. Like the other pavilion, it is thoroughly ventilated, and heated by hot air, forced through the register. In this new pavilion have been placed three private rooms for pay-patients suffering from diphtheria only. Both pavilions are connected by a hall-way, which contains the main entrance; the resident-physician's room is also situated in the east end of the new pavilion, as is also the dining-room. Like the older pavilion, the new one is complete in itself, and is the most attractive building of the group. It is divided into two wards, the floors, walls, and ceiling being painted, and the capacity being 60 patients. Patients are brought to the hospital by two ambulances of modern design, one for cases of diphtheria, and one for cases of scarlet fever.

The institution can accommodate 356 patients, as follows:

The extreme capacity of the main building is.....	200 beds
The extreme capacity of the pavilions, sixty each, is.....	120 beds
The capacity of the portable hospital is.....	36 beds
Total.....	356

At the present time there is no small-pox in Philadelphia, but should a case occur the authorities would be in an embarrassing position, for all the buildings are now in use, as follows:

The main building for scarlet fever cases only; the pavilion hospitals for diphtheria cases only; the portable hospital for cases of scarlet fever, suffering from diphtheria also.

The important fact should be recognized that the Municipal Hospital has permanently become the place of reception for the commonly prevailing contagious diseases, and will continue to be so with an increasing ratio of cases. This is the first merit, for, as physicians, we have the assurance that there is one place to which we can send our contagious cases, without regard to character, whether mild or severe, whether the patient will live or die. The Municipal Hospital will receive all such cases without question; and will take care of them and treat them, in many respects, far better than they would ordinarily be treated at home.

The second merit of the Municipal Hospital is that it stands as a bulwark against contagious diseases. It prevents their spread by receiving the first cases, keeping them until the patients are well, and removing all danger of infection. In this way its benefit to the public can never be estimated. If due publicity were given to the cases admitted early, and spread of the disease thus prevented, the claims of this hospital on the municipal treasury would receive a prompt consideration.

The third merit of the hospital is the conspicuous fact that the builders builded better than they knew, for, in placing the hospital at its present site, they chose the best locality for the good of the people. Centrally located, almost equi-distant from the farthest parts of the city, situated between two lines of railroad, so that residential improvements are totally out of the question, and in a tabooed section of the city, the hospital has been an improvement to the neighborhood, and no just complaints have arisen warranting its removal.

Unfortunately, this hospital has also some demerits, and, while they cannot eclipse its good points, they are sufficiently

important to call for some attention. First: The old building should be improved. The piazzas, as suggested by Dr. Welch, should be enclosed with windows; they could then be used as sun parlors in winter, or as additional wards when the other wards become, as is frequently the case, overcrowded.

Second: No provision has been made for a home for the nurses. As is so generally known, disease spreads amid crowding, and a nurse might become the carrier of contagion. For this reason, among others, separate buildings should be constructed for each group of nurses. At present, such precaution is taken with the resident physician, but the means are inadequate to do so with the nurses.

Third: It is not the part of wisdom to group together the virulent and the mild cases of contagious disease. At present cases of measles and whooping-cough are not sent to the Municipal Hospital, but go to the Philadelphia Hospital. It would be good policy to have a suitable hospital built at some distant point for small-pox cases, and to leave the Municipal Hospital for scarlet fever and diphtheria.

Fourth: The grounds are inadequate to meet the requirements of a modern hospital. The city should acquire possession of the surrounding land, which will always remain unsuitable for residential purposes by reason of the close proximity of the railroads. On this ground suitable buildings should be erected for the nurses, the physicians and the patients.

Especially for the patients there should be erected such buildings that could be used for the reception of suspected cases, and also buildings that could be used for those convalescing. No provision has ever been made for these two groups of cases, and the cost would be but the least important item.

At present there are no private rooms except in the diphtheria ward, and for diphtheria patients only. Provision should be made for those who can pay and are willing to pay. That the hospital lacks this has been one of the main factors that has prompted those interested in the public health to agitate for a pay hospital for contagious diseases.

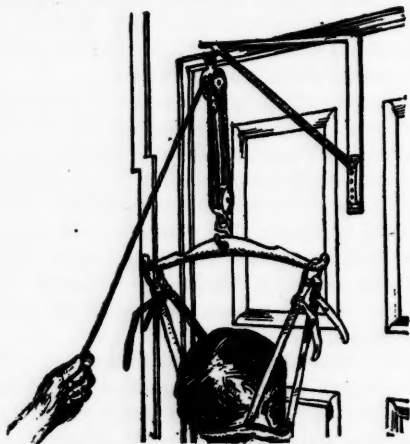
PORTABLE DOOR ATTACHMENT FOR APPLYING SUSPENSION.

H. AUGUSTUS WILSON, M.D.,* PHILADELPHIA.

The great advantages to be derived from suspension in the many cases susceptible to its use are seriously neutralized by the inconveniences of the apparatus heretofore employed. The value of suspension in the diagnosis of spinal lesions has long been recognized, and its use as a therapeutic measure would be more frequently resorted to at the residence of patients but for the difficulties referred to.

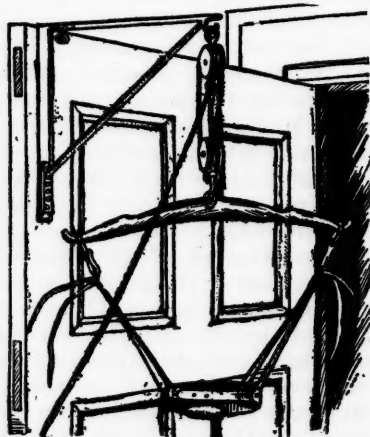
The arrangement that I suggest, which is an adaptation of the painters' "jack," is intended to overcome the disadvantages of the cumbersome tripod, and the various fixtures that are screwed into the walls, ceiling or woodwork. Its use does not tend to terrify the patient by its gruesome

method a wedge of some sort should be placed under the door to prevent too great strain upon the hinges. The thin steel used permits the horizontal bar to occupy the space that usually exists between the top of the door and the jam, and yet the device is sufficiently strong to sustain a weight of two hundred and fifty pounds. It is adjustable to doors varying from one



appearance, nor does it leave defaced paint or plaster as reminders of the ordeal. The simple construction of the bracket renders easy its attachment to any convenient door, and its speedy removal leaves no trace of its use.

In the first illustration the bracket is shown in use, with the door closed, so as to avoid draughts upon the patient, while the second illustration shows its use with the door standing open. In the latter



to three inches in thickness, and even a thin closet-door can be used to suspend a child.

It will be perceived that to the bracket may be attached any desired form of suspension and extension apparatus, such as axillary supporting bands, in addition to the head-rest shown; or the suspension-extension apparatus recommended by Dr. S. Weir Mitchell may be as conveniently employed. The applicability of the apparatus to medical and other gymnastic work will be apparent, and further uses will readily manifest themselves as the requirements are presented.

When graduated and exact extension is demanded an ordinary spring weighing-machine can be interposed between the hook on the bracket and the suspension apparatus proper. This method has been satisfactorily employed by having the pa-

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tient seated in a chair, with the back to the door upon which the bracket was attached; extension to the desired number of pounds being obtained, the rope made fast and the definite length of time of suspension-extension noted by a watch.

The entire outfit, as shown in the cuts, consisting of bracket, rope, pulleys and

head support, weighs only eight pounds, and when taken apart will occupy but little space in a physician's bag. I desire to acknowledge my appreciation of the faithful execution of my designs by Mr. A. Gustaf Gefvert, mechanician to the Jefferson Medical College Hospital, from whom the apparatus may be obtained.

THE VALUE OF APIOLIN IN NEUROTIC DYSMENORRHEA.

D. S. MADDOX, M.D., MARION, O.

Dysmenorrhea is one of the most frequent complaints the general practitioner is called upon to treat. That it is one most obscure in etiology, as well as one of the most difficult to permanently relieve, all physicians will admit.

Most authorities divide dysmenorrhea into the neuralgic, the obstructive, the congestive or inflammatory, and the membranous forms. The frequency of these varieties is in the order named. In other words, the most frequently met is the neuralgic form, and the least frequent is the membranous.

While one who has had experience can readily determine the character of the case by the character of the symptoms, and although we do occasionally find these typical varieties, it is doubtful if any case continues one of any of these (distinct) varieties for a long period of time. Thus, a neuralgic dysmenorrhea does not long remain purely such. It is impossible to suffer great pain during the function of menstruation continuously, month after month, and year after year, without structural changes in the endometrium resulting. Neurotic dysmenorrhea in time becomes congestive, and, finally, inflammatory dysmenorrhea.

In a certain sense, every dysmenorrhea is mechanical. Neuralgic dysmenorrhea is certainly mechanical when spasmodic; for instance, when there is spasmodic action of the fibres of the cervix, analogous to the spasmodic action of the sphincter ani in fissure of the rectum. There is a mechanical obstruction in dys-

menorrhea when the cause was originally a flexion or displacement. Sooner or later, the neurotic element enters into all cases of dysmenorrhea. Of course, obstruction is one of the chief underlying factors in causing pain in some cases of dysmenorrhea. It is a well-known fact that savage women suffer much less during labor than their civilized sisters, possibly because a higher development of the nervous system is incident to civilization. It seems natural to suppose that this high development of the nervous system makes menstruation more painful; or, in other words, that the pain, at least in part, is nervous or neuralgic. Dysmenorrhea in young women is often caused by improper mode of life, and for the relief of such it is not the gynecologist, but the general practitioner, who should be consulted. The latter, by proper advice and judicious medication, can and will usually give them relief without the examination, which, in unmarried women, when unnecessary, is little less than a crime.

Some recent authorities deny the existence of a pure neuralgic dysmenorrhea, attributing all cases of dysmenorrhea to infection and arrested development. I think, however, that most practitioners believe there is such a thing as neuralgic dysmenorrhea. I regard it as the most frequent form of dysmenorrhea, coming on at the very beginning of menstruation, and, it may be, lasting until the end of menstrual life; and it is the most troublesome form to treat in many instances. One reason for believing in its existence

is the conduct of cases, and the manifestation of symptoms. Some of these cases begin at the very inception of menstruation; some not until months afterwards; some not until after married life; and some not until after parturition.

Some, when they have begun, or later on, stop for one or several months or a few years, and then for some cause return again. There is great irregularity regarding time, duration and the position of the pain in these cases. Not a few of these cases suffer irregularity in quantity at different times, and not a few cases suffer irregularity in position at different times.

In the treatment of dysmenorrheal cases, where there is no tangible pelvic lesion demanding strictly local attention, or operative interference, I have of late come to rely on a single remedy; apiolin, the active principle of *petroselinum sativum*, introduced to the profession by Chapoteaut. The following cases are of the neurotic variety of dysmenorrhea, and clearly demonstrate the value of the drug as a therapeutic agent.

CASE I. Miss F., aged 20, anemic and poorly nourished. For two years she had suffered greatly from painful and scanty menstruation. At times the pain was so severe that the hypodermatic use of morphia was resorted to. An iron tonic was

prescribed; also, apiolin at the menstrual periods, beginning three days before the flow was due. In three months the patient was much improved in general health, and her menstruation was normal.

CASE II. Mrs. R., aged 34, married ten years, three children, youngest two and a half years old. Had had painful and scanty menstruation off and on for nearly four years. When I first saw her she had had four painful periods in succession. Apiolin was ordered (one capsule three times a day) during the flow, beginning as usual two or three days in advance. The effect was immediate, pain being slight, and the flow more copious. The second month there was no pain, and flow was normal in quantity.

CASE III. Mrs. B., aged 27, married five years, one child two years old. Previous to marriage had suffered from painful menstruation, but after marriage the attacks had subsided, and only recurred after the birth of her child. The pain experienced was of a severe character, necessitating confinement to bed and opiates. She was put on apiolin (one capsule three times a day), beginning three days before the period. This remedy was continued for three months, after which menstruation was normal.

CURRENT LITERATURE CONDENSED.

Some Unusual After-Effects of Strychnia Poisoning.¹

In June, 1895, a man consulted my father and myself on account of pain and spasms in his upper and lower extremities, accompanied by occasional twitchings of the muscles of the face. In October, 1892, he had been poisoned by strychnia, the dose taken having been about twenty grains. He was at once given a large quantity of snuff and water, which immediately caused free vomiting.

My father saw him about half an hour after the poison had been taken. He was then suffering from severe spasms of the whole body and opisthotonos, and was un-

able to swallow. Inhalations of chloroform were kept up from 10 P.M. until the following morning, being given whenever the spasms came on; subsequently, when he was able to swallow, a chloral and and bromid mixture was given by the mouth. He recovered perfectly from the immediate effects of the poison and returned to his work in the ensuing week.

In May, 1895, two and a half years after the poisoning with strychnia, my father was again sent for, and found the patient suffering from spasms in his limbs and back; the attack, however, was not very severe and passed off under the use of chloral and bromid. It was practically impossible to obtain a proper history of

N. B. DARABSETH, M.R.C.S. Eng., in *The Lancet*.

his condition during the period which had elapsed since the poisoning. He said that for the first six months he was fairly well, although weak and sore; then he once got wet by exposure to rain, and from that day he suffered in his limbs and back from pains which were supposed to be rheumatic both by himself and by several medical men who treated him.

In June, 1895, according to my notes, his condition was as follows: He was twenty-eight years of age, had an anxious look, and of late had been slightly dull and forgetful and very languid. He complained of aching pains and formication in both the upper and lower extremities and of fatigue on the slightest exertion. He had peculiar sensations in his limbs sometimes as of burning, at other times as of sitting on an ice-cold seat. In the upper extremities he often felt as if an insect was running with great rapidity down his arm to the fingers; sometimes the sensation was as if the insect stopped half way.

Some of the muscles, such as the deltoid and the deep muscles of the back of the neck, were in a constant state of contraction, so that they felt hard; his walk was erect, with the head slightly thrown back. He complained of pain in the shoulders and in the back of the neck and head. No actual spasms in the limbs were noticed during the daytime, but while walking he used to feel his legs start up quickly, which made locomotion easier for him, and the muscles of his face sometimes twitched whilst he was in the act of speaking, especially the orbiculares palpebrarum and the dilators of the nose; he always felt tired after even a short walk. The right arm was harder over the deltoid and also larger by half an inch than the corresponding portion of the left arm. At night he was generally restless and subject to sudden startings in the legs, hands, or back, which had the effect of waking him if he happened to be asleep.

Chloral gave immediate relief, and he could not sleep without it. The spasms did not cause cramps, but came on in jerks like electric shocks, and generally occurred either when he was engaged in some work or else when he was asleep. When he was sitting quietly or talking his fingers would become abnormally ex-

tended. The patellar reflex was exaggerated. The pupils and optic disc were normal, and he had no nystagmus or headache, although he suffered from pain in the back of the neck due to the contraction of the muscles. His gait was quite normal; he could also stand with feet close together and eyes closed, and there never was any weakness in the legs, but only a feeling of fatigue as if from overwork. He was constantly under the impression that he would become paralyzed, which made him very anxious and melancholy.

The only drugs that gave him immediate relief were chloral and bromid, but the effect was only temporary and great depression ensued. Belladonna, gelsemium, physostigma, and ergot were successively tried, but they caused additional spasms or tremors, and after three or four days' trial of each the patient refused to continue the treatment. Tincture of belladonna was again tried in two-minim doses and gradually increased to fifteen minims three times a day, after five months of which treatment, combined with tonics such as iron and quinine, the patient gradually improved. The shocks and spasms became gradually less, and by the month of November the muscles of the arm and back of the neck were relaxed, there were only very slight and occasional attacks of spasm at night, and the patient was consequently able to sleep well. I last saw him in March, 1896, and found him comparatively well and cheerful. He said that he still felt shocks occasionally, but he was able to attend to his work and even to take long walks and play cricket.

I believe that the pain and spasms were due solely to the overdose of strychnia, that they must have begun not long after the immediate effects of the poison were recovered from, and that they were the symptoms which were mistaken for rheumatism, not only by the patient, but by some of his medical advisers unaware of his previous history. I have, however, not read of a poisonous dose of strychnia causing such symptoms continued over so long a time, for, ordinarily, if the case does not prove fatal the patient recovers quickly without experiencing any after-effects. It is very difficult to understand

why the symptoms should persist so long. I believe that the very large dose which was taken caused congestion of the spinal cord, and that this passing into a chronic stage gave rise to these reflex symptoms. Belladonna was the only drug which seemed to be useful; it probably acted as a spinal sedative. Ergot was given with the expectation that it would relieve congestion, but it caused more spasms and had to be stopped after three days. The patient is certain that no medical man gave him strychnia or nux vomica; he always read the prescriptions, and said that what was ordered was generally potassium iodid.

Libel and Slander as Affecting Physicians.¹

Libel consists in the utterance of any communication otherwise than by oral speech unjustifiably accusing private individuals, officials or governments of anything tending to make them ridiculous or injure them in reputation or public esteem. Slander is an oral statement unjustifiably accusing a person of a crime, a loathsome disease, incapacity, or dishonesty, or of any fault which tends to injure the person or his business. The courts have decided that an accusation may be slanderous or not according to the vocation of the accused. To accuse a physician of general professional ignorance or malpractice is actionable per se, but to state that in a special case he was at fault is not slanderous, unless special damage is proved. A retired physician, since he no longer gains his living by his profession, may be accused with impunity of what would "slander" a man in actual practice. Slanderous words uttered in one state may not be actionable in another state unless proved to be so also in the place uttered. A person uttering slander to a second party who repeats it to the detriment of an individual may escape responsibility if the damages result from the utterance of the second party and not from that of the originator. In case of libel, any accusation holding a person up to scorn or ridicule, whether professionally or as a private person, is actionable. A physician who attempts to achieve notoriety by puffing

himself cannot recover damages from those who further his attempts. It is slander to falsely attribute a contagious disease to a person, unless a statement was necessary and there was a mistaken diagnosis.

State Medicine in Pennsylvania.²

A good many changes were made in the health laws by the last Legislature. A new act constitutes a sanitary code for the restriction of epidemic diseases. It makes sanitary administration uniform throughout the State, and authorizes Boards of Health to enforce its provisions independent of municipal regulations.

An act for the prevention of blindness was passed. From 1870 to 1880 the population of the State increased 21.6 per cent., while blindness increased 119.8 per cent., ophthalmia neonatorum being the most productive cause. The act requires the nurse or midwife to report to the Health Officer within six hours after the appearance of inflammation or redness of the eyes of an infant, which officer is required at once to send instructions for treatment. The Cr  d   treatment is used, a prescription for a two-per-cent. silver nitrate solution being appended, together with directions for after-treatment and prophylactic measures.

Small-pox has appeared at only five points during the year, the very general vaccination in 1894, together with the enforcement of the law for compulsory vaccination of school children, largely causing this immunity.

Philadelphia maintains its unenviable reputation as a typhoid centre, the death ratio in 1895 being 40 per 1000 population as against 17 in New York and 16 in Brooklyn. This is due to the polluted water-supply. In Girard College typhoid was once found to be almost always present. The water used by the students was pumped directly from the Fairmount forebay in the Schuylkill, without even sedimentation. A filtering plant was introduced, and typhoid soon disappeared. An excessive fever death-rate prevails among the population immediately outside the college walls, who are using unsedimented, unfiltered water.

¹ Henry Leffmann, M.D., in *Philadelphia Poly-clinic*.

² Dr. Benjamin Lee in the *Sanitarian*; condensed from *Medicine*.

The sudden and permanent fall in typhoid deaths in Kensington, coincident with a change from the Delaware river water to that from East Park reservoir, where the water is sedimented and aerated, adds another to the proofs that filtration will remove this deadly potency from polluted water.

The Results of One Hundred and Forty-seven Operations for Retroversion of the Uterus.⁴

The paper was based upon ninety-four ventrofixations, and fifty-three Alexander's operations. The author held that ventrofixation was the only operation that should be entertained in cases of retroversion with adhesions, but it should not be done when the uterus was movable, and when there was no disease of the appendages requiring abdominal section, in which cases Alexander's operation had given excellent results. There should be no death rate to either operation, neither should there ever be hernia, either ventral or inguinal, if the following directions were followed.

The two operations were equally easy, although a few years ago the author was opposed to Alexander's operation on account of its difficulty. Now he could invariably find the ligaments, and generally in from half a minute to a minute and a half. He warned his hearers not to do Alexander's operation if there were any adhesions, even if they were loose enough to permit the uterus to be lifted up, because they would be put upon the stretch, and would drag so much upon the ligaments as to finally pull them out of their anchorage.

In laying down the technic of Alexander's operation he placed great stress upon the importance of putting aside all cutting instruments so soon as the skin, superficial and deep fascia, had been cut through. Instead of laying open the inguinal canal, as advocated by some writers, he advised his hearers not to cut a single fibre of the intercolumnar fascia, which was the principal support of the pillars. Moreover, he said, the slightest nick of the fascis of the internal oblique would

lead to a false passage, and failure to find the ligament.

If no cutting instruments were used, but only a Peans forceps to draw out the ligament, there would be no difficulty in finding it, because there was nothing else in the canal but the ligament. In fact, with the eyes bandaged, it could be found and drawn out, simply by introducing the closed forceps, and then opening them, when the round ligament will fall into them, and can be drawn out.

He advocated the use of fine silk-worm gut, which could be thoroughly sterilized and left in permanently. Occasionally he had been obliged to remove a buried stitch. In case any fibres of the intercolumnar or internal oblique should be accidentally cut, great care should be exercised in sewing them up to avoid hernia.

He had only had one relapse after ventrofixation and one after Alexander, which were both subsequently repaired. Several of the cases of ventrofixation had since become pregnant, and had had normal confinements. Also several cases of Alexander operations had had children. Many of the patients had been bed-ridden invalids for years before, and were now enjoying excellent health. Both operations, each in its proper sphere, had given the greatest possible satisfaction.

The Effect of Diet upon the Fits of Epilepsy.⁵

Haig (*Brain*, 1896, Part 2, xxiii, p. 68), after a careful study of the subject, believes that the uric-acid fluctuation is the cause of the fits. By a carefully selected dietary he has found that the intake and formation of uric acid can be so reduced that the fluctuation shall never, or only very rarely, be sufficient to affect the blood-pressure and the intracranial circulation to a serious extent. The epileptic wave of excretion runs very high, but only for a short time, and it is very difficult to keep the general level of uric-acid excretion so low that these waves shall not occasionally get high enough to do damage by raising the blood-pressure,

⁴ By A. Lapthorn Smith, B.A., M.D., M.R.C.S.; England.

⁵ *The American Journal of the Medical Sciences*, April, 1897.

and affecting the intracranial circulation. Here flesh food must be avoided entirely, and all soup and meat-extracts regarded as poisonous; while tea, coffee, and cocoa, and all other vegetable substances containing xanthin compounds are to be regarded as producing uric acid, and used, if at all, only as the merest flavoring. From the facts mentioned in this paper it is pretty clearly shown that the fits of epilepsy, and convulsions in general, have an extremely close relationship to the uric-acid headache (migraine), and, like this, are probably functional disorders due to altered circulation in the brain, this again being due to the contracted arterioles and high blood-pressure caused by uric-acid. Since this headache is controlled with almost absolute certainty by a diet which frees the blood from the excess of uric-acid, it is hoped that it will be found that fits will in many cases yield in the same way to well-directed treatment.

Saline Injections.*

Lachelongue, after tracing the history of saline injections since their first introduction by Joehrnichen, of Mexico, in 1830, summarizes the results which have been obtained by them. He shows that in cholera, pneumonia, typhus and typhoid, scarlatina, and other infectious fevers, also in diabetes, uremia, paroxysmal tachycardia, there is invariable improvement in the general condition, and lowering of temperature, with increase of blood-pressure and increased renal activity.

Good results have been frequently obtained by subcutaneous injections when intra-venous injections produced inactive or injurious results. The amount injected is from two to six hundred grams. These injections are also found useful in shock and hemorrhage; while fever is no contra-indication, and hyperthermia is not to be apprehended. The injections may be used in anemic cases requiring surgical operations, either before or afterward. A two-per-cent. solution of the neutral phosphate of soda, suggested by Crocq, is useful as a tonic in these cases. Chil-

dren in a state of collapse from intestinal affections, are often benefited and sometimes saved by this means.

Injections are also indicated in infectious enteritis with subnormal temperature, and in chronic disorders with great debility and low temperature. They have no effect, however, on general nutrition, on diarrhea, or other symptoms than those of collapse. Hayem considers this method of no value in gastro-intestinal dyspepsia, although he approves of its employment in choleric conditions.

Fate of the Apostles.

The following brief history of the fate of the Apostles may be new to those whose reading has not been evangelical:

St. Matthew is supposed to have suffered martyrdom or was slain with the sword at the city of Ethiopia.

St. Mark was dragged through the streets of Alexandria, in Egypt, till he expired.

St. Luke was hanged upon an olive tree in Greece.

St. John was put into a caldron of boiling oil at Rome and escaped death. He afterwards died a natural death at Ephesus in Asia.

St. James the Great was beheaded at Jerusalem.

St. James the Less was thrown from a pinnacle or wing of the temple and then beaten to death with a fuller's club.

St. Philip was hanged up against a pillar at Hieropolis, a city of Phrygia.

St. Bartholomew was flayed alive by the command of a barbarous king.

St. Andrew was bound to a cross, whence he preached unto the people till he expired.

St. Thomas was run through the body with a lance at Coromandel in the East Indies.

St. Jude was shot to death with arrows.

St. Simon Zelotes was crucified in Persia.

St. Matthias was first stoned and then beheaded.

St. Barnabas was stoned to death by Jews at Salania.

St. Paul was beheaded at Rome by the tyrant Nero.

* Th. de Paris, in *Mod. Medicine*.

TRANSLATIONS.*

Sciatica Treated by Compression over Painful Area.

Negro, of Turin, has succeeded in curing 100 out of 113 cases of sciatica by digital pressure over the painful part (*Berlin. klin. Woch.*, No. 14, 1896). His method is as follows: The patient assumes ventrodecubitus with extremities well extended and adducted. This secures relaxation of the muscles around the canal from which the sciatic nerve emerges and facilitates locating exactly the seat of the pain. On the painful spot the end phalanx of the right thumb is superimposed, and aided by that of the left thumb is pressed firmly and with all possible force for fifteen or twenty seconds, and pressure is repeated for some length of time after an interval of a few minutes. The patient is then usually able to walk, and at times is free from pain. The entire procedure is repeated in two days. In the majority of cases six treatments are sufficient.

Dressing Suppurating Wounds with Sodium Bicarbonate.

M. N. Guorguievsky recommends the employment of moist sodium bicarbonate dressings for abscess, phlegmon and paronychia. To obtain the best results a compress saturated with a two per cent. solution of sodium bicarbonate should be applied directly to the diseased tissue, after incision and gentle expression of the pus. In two cases of phlegmon and serious paronychia with extensive suppuration where the ordinary antiseptic dressings were used a long time without effect, sodium bicarbonate arrested the process very rapidly, all traces of pus having disappeared within a few hours, and there was no necessity for the introduction of gauze tents into the open wound. Absence of odor, positive and rapid action, and cheapness of this new

dressing are advantages so evident that it is not necessary to dwell on them.

Treatment of Abortion.

The varied opinions on this subject have led M. Abel (*Médec. Mod.*, 1897, p. 165) to advise the methods used by him in 200 abortions. In incomplete abortions of recent occurrence, the cervical canal being penetrable by at least one finger, the retained placental tissue should be removed by digital curetment. After a few weeks the os is closed and there are then two operative measures to choose from: First, the immediate employment of the curet; second, curetment following dilatation. The first, although frequently advised by others, Abel rejects as dangerous, brutal, and incomplete. He advocates dilatation by Landau's method, as follows: The genitalia are cleansed with soap and water, and a disinfectant is rubbed on the vaginal walls. The uterus is then drawn down and a strip of absolutely sterile iodoform gauze is introduced into the cavity so far as the fundus. This is removed in twenty-four hours, and if dilatation is then insufficient to admit the finger another tampon is inserted. After digital exploration and curetment the uterine walls are washed with a cotton-wool tampon soaked in a five per cent. carbolic acid solution. If hemorrhage is not arrested, tamponing the uterus is again practiced. The same procedure may be resorted to in septic endometritis. The temperature falls very rapidly after the cleansing, and Abel, therefore, disagrees with Olshausen, who considers it justifiable to extirpate the uterus in septicemia after uterine operations. In threatened abortion, attempts are made to avert the accident (rest in bed, etc.). If necessary the vagina may be packed to prevent the expulsion of the embryo. In hemorrhage after abortion due to presence of decidual sarcoma, radical operation is imperative.

* Translated for the MEDICAL AND SURGICAL REPORTER by Dr. H. Kirshbaum.

Ergotinol to succeed Ergotin.

After using ergotinol exclusively for three years M. Abel (*Berl. Klin. Woch.*) reports some remarkable results obtained from its use. The principal advantages of this substance are its easy administration, rapidity of action and its stability. This last quality is rarely met with in the other preparations of ergot, all of which rapidly decompose, and their employment is thus rendered dangerous. Ergotinol can stand several years without undergoing the slightest change. Secondary phenomena have never been observed, nevertheless its injection presents a serious objectionable feature in causing severe pain. This may be avoided by adding small doses of morphin or cocain, which do not modify the principal action of ergotinol. Indications for use are exactly the same as for ergot,—in acute hemorrhage, especially post-partum or post-abortive, in metrorrhagia due to fibroma or other causes. Maximum dose used was 30 minims daily. In a case of fibroma with excessive menorrhagia Abel gave one injection daily for eight days during the menstrual epoch with excellent results. In conclusion, ergotinol is recommended as a substitute for ergotin as it possesses all the commendable qualities of the latter, and none of its ill features.

For Vomiting in Intestinal Diseases.

(*Med. Mod.*, p. 146, 1897.)

R—Menthol, gr. viij.
Cognac, fʒ x.
Tr. Opii, fʒ ijss.
M. et S., 20 drops several times daily.

New Surgical Antiseptic.

Amyloform is a combination of formic aldehyd and starch, forming an odorless white powder, insoluble in any liquid, very stable, and not affected by temperature of 180°. (*Med. Mod.*, p. 146, 1897.) The great bactericidal antifermentive and antiputritive power possessed by formaldehyd makes amyloform a very active surgical antiseptic. The powder applied to wounds rapidly diminishes their secretions, and destroys the bad odor. No local irrita-

tion or intoxicating symptoms have been observed.

Toothache Remedy.

S. Voïtoff recommends an unfailing remedy for toothache, consisting of:

R—Cocain hydrochlor., gr. jss.
Camphoræ.
Chloral hydrat., āā, gr. lxxv.
Aq. destil., gtt. quibusd.
M. et trit. until clear liquid is obtained.

A small cotton pledget saturated with this solution is put in the cavity of the tooth, and allowed to remain an entire day. Ordinarily the pain ceases at once, but if a little pain persists apply a new tampon. The pain then disappears completely. This mixture is disinfectant, as well as analgesic. (*Med. Mod.*, p. 146, 1897.)

For Spermatorrhea and Anaphrodisia of the Neurasthenic.

(*Med. Mod.*, p. 146, 1897.)

R—Cornutin. citrat., gr. ʒ.
Creta. prepar., gr. lxxv.
Gum tragacanth, ʒjss.
M. et ft. in pil. No. 20.
Sig.—2 to 4 pills daily.

Mirth is God's Medicine. Everybody ought to bathe in it. Grim care, moroseness, anxiety,—all this rust of life, ought to be scoured off by the oil of mirth. It is better than emery. Every man ought to rub himself with it. A man without mirth is like a wagon without springs, in which one is caused disagreeably to jolt by every pebble over which it runs.—*Beecher.*

The seven Bibles of the world are the Koran of the Mohammedans, the Tri Pitkes of the Buddhists, the Five Kings of the Chinese, the Three Vedas of the Hindoos, the Zend-Avesta of the Persians, the Mormon, and the Scriptures of the Christians.

Birds readily recognize pictures, and stories of their pecking at painted fruit may well be true, for they readily recognize the picture of another bird, and the little "love-bird" may be saved from moping when alone by placing the picture of a companion in the cage.

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PHILADELPHIA, SATURDAY, JUNE 5, 1897.

EDITORIAL.

COLLECTING AGENCIES.

The elaborate and often conflicting schemes to keep men of all kinds of business informed as to the honesty of prospective customers and clients, is a sad commentary on the honesty of the nation. Few reforms of the last century have been more needed than the abolition of imprisonment for debt, but the pendulum has swung too far toward mercy and too far from justice. Persecution of a debtor not only is unmerciful, but it takes away his opportunity for doing justice to himself and to his creditor. On the other hand, the pampering of the dead beat, enforced by the laws of most of the United States, is nothing more than subsidizing the dishonest. We must never lose sight of the fact that a man who does not pay his debts—unless prevented by some terrible and unforeseen calamity—is a thief.

So much for the ethics of various forms of protection against dishonest debtors.

The practical operation of organizations for this purpose is not what might be hoped for. In the first place, popular sentiment and the enforcement of laws during three generations which favor the debtor and limit the owner of borrowed money or borrowed labor to the meekest requests for his property, have thoroughly taught the shiftless that they need not pay their debts if they do not want to. "Spend your money at the saloon freely, marry a woman who will help support you by taking in washing," says the law to the poor man, "and you may have whatever you can manage to take from others, without actually climbing into their houses or picking their pockets." And if the man ventures to ask, "What will become of me if I don't lay up something against a rainy day?" the demagogue and the philanthropist answer in one breath, "Don't worry about that; we will fur-

nish grocery orders when you are hungry, coal when you are cold, some sort of a shelter when you can no longer cheat the landlord, a hospital if you are sick or injured, or whenever your wife is confined."

We are not attempting to argue on the ethics of debt, but merely to point out the improbability that organization in the face of existing law and sentiment will enable the creditor to collect money where he was not able to do so before. A few men, finding themselves known to strange grocers, butchers and doctors, and their attempt to obtain credit by moving from one part of a city to another, balked by collection associations, will reform; the remainder will seek open charity or will move to another town. Still, physicians should, as a matter of principle, support any organization which will help a little in the right direction. There are really not so very many dishonest persons in the world, probably not more than a quarter of the total population. But as the dead-beat class—viewed of course from the commercial standpoint, not the ethic—includes women and children, a list of a thousand delinquent debtors represents a population of perhaps six or seven thousand who are commercially undesirable. Thus, even in a good-sized city, the class which is stealing from forty to fifty per cent. of the total earnings of the physician, may be represented by a list of only a few thousand names.

From motives of humanity such list must not be used too rigorously; even rank dishonesty does not warrant the neglect of actual acute suffering, and certainly an innocent child should not be allowed to suffer for the sins of his parents. But, beyond giving first aid to such cases, they should be referred to organized, public medical charity; they should be made

to understand that they are a class by themselves; that they are recognized as an unnecessary tax on the honest and provident members of society, and that the latter, while too kind-hearted to permit actual suffering, must insist that the burden of such be carried equally by society at large and not by private charity.

The profession is just at the beginning of an organized endeavor to free itself from the burden of the dishonest debtor. It must not expect too much in the way of direct results; no effort of science can extract blood from a red beet nor money from a dead beat. But persistence in these measures is part of the duty of every honest man; it is a duty not mainly to ourselves; but to society at large and to the debtor himself. Mawkish popular sentiment has placed a premium on dishonesty and shiftlessness. Let each do their little toward producing a reaction.

A man to avoid paying a debt of ten dollars may put aside opportunities to invest in real property, and may form the habit of spending money as he gets it. The creditor who insists on collecting that ten dollars may be only five dollars better off himself, but he may have given his debtor an education in business honor that will make him a responsible and wealthy citizen, while the boon to society at large is inestimable.

Twenty-five years ago public begging and indiscriminate charity at the side-door was the custom. This evil has been almost entirely abolished, and both begging class and almoners have been benefited. It will be equally possible by persistent, honest effort, to bring the dead-beat class outside the scope of private benevolence, to reduce its numbers and to impose the burden of the incurably dishonest on the general tax rate.

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ABSTRACTS.

THE INDICATIONS AND LIMITATIONS OF CELIOTOMY.*

Liver, by Dr. H. H. Mudd.—The cysts, the adenomata, the dermoids, and the malignant tumors of the liver offer occasional opportunities for celiotomy. This is limited because the cysts are often multiple. The tumors and dermoids are very rare, and carcinoma is a secondary affection. In abscesses of the liver celiotomy is justifiable, and demanded whenever the abscess can be detected before adhesions have formed to the parietal peritoneum. Gall-stones may be successfully removed from the gall-bladder, from the hepatic duct, or from the common duct. Celiotomy is demanded when cholangitis is marked; when the gall-bladder is in danger of rupture; when there is sepsis; when colic is frequent, and jaundice is persistent; when pain is constant, and organic disease can be excluded.

Kidney, by W. A. McCandless.—Division of subject into topics: 1. Movable kidney. 2. Floating kidney. 3. Suppurative diseases of kidney. 4. Renal calculi. 5. Tumors of kidney. 6. Wounds of kidney, subparietal and penetrating.

Argument.—Some floating kidneys and some tumors should be removed by celiotomy. Other diseases should be treated by lumbar incision. Celiotomy is no aid to diagnosis.

Intestinal Obstruction, by Dr. H. C. Dalton.—Having determined that the obstruction exists, its exact character must be determined. Many cases are relieved without an operation; notably, obstruction due to fecal impaction, reducible hernia, sometimes intussusception and occasionally graver conditions subside before an operation becomes imperative. For instance, an intestine may slip out of a slit in the mesentery from underneath a band or from an arch, however formed. Etiology is important, and differential diagnosis almost essential.

A positive diagnosis before opening the

abdomen is seldom made, though it is possible in hernias, where we can locate the tumor, in acute intussusception, where we can feel a sausage-shape mass; likewise, a former peritonitis may point to a peritoneal band, and the same conclusion may be drawn if the patient has been the subject of a previous celiotomy. If the trouble be located about the sigmoid flexure, with sudden and intense ballooning of the belly, we almost certainly have to deal with volvulus. Where we have grave symptoms pointing to obstruction present, it is better to make the diagnosis by putting two fingers through a two-inch incision than to wait until the symptoms are so evident that any tyro in surgery can make the diagnosis. Anesthesia furnished the best means of diagnosis in doubtful cases, and a simple incision adds but little to the gravity of the case. A two-inch incision is not always sufficient. Renal and hepatic colic, lead colic, arsenical and other poisons, acute peritonitis, tainted food, etc., give symptoms very similar to obstruction. The history, occupation and ingesta will assist materially in diagnosis. Free purgation often relieves a local peritonitis. It is not to be advised when obstruction may exist. The use of opiates when obstruction is suspected is condemned.

Intussusception is by far the most frequent cause, occurring in three-eighths of all cases; next, strangulation by bands, occurring in one-fourth of all cases; then follow volvulus, hernias and other varieties. Intussusception may sometimes be relieved by insufflation of air, large enemata or carbonic acid gas. A surgeon is rarely called to a case of obstruction until the general practitioner has administered a number of doses of opium and cathartics; drastic cathartics and irritating enemata have been given until the case has assumed a very grave aspect. Almost all such cases die, their vitality being so low that they cannot withstand the anesthetic and simple incision, leaving out of view

* Papers read before the St. Louis Medical Society, and abstracted in the *Hot Springs Medical Journal*.

the manipulation necessary to relieve the condition. Many cases, which might otherwise be saved, are prolonged by anesthesia and manipulation. Having operated and found the obstruction, the method of relief comes up.

In extremely bad cases, where time is a great factor, we must be content with a simple ileostomy (the formation of a fecal fistula). Bowels should be kept as much as possible in the abdominal cavity, as manipulation and bruising same, as well as contact with air, are potent factors in adding to the shock.

Non-Traumatic Perforations of the Intestines, by Dr. A. F. Bock.—The indications and limitations of celiotomy for non-traumatic perforations of the intestines have not up to the present time been fully determined. Non-traumatic perforations which may call for celiotomy are: Perforating typhoid ulcer, perforating stercoral ulcer, perforating duodenal ulcer, perforating tuberculous ulcer. The typhoid are the most common variety of perforations; up to the present time there have been about 47 operations reported, with 13 recoveries. The indications for celiotomy in perforating typhoid ulcer are mainly sudden and acute, and continued pain in the abdomen, associated with nausea and vomiting, and followed by shock and collapse, general peritonitis and supuration. An abrupt fall of the temperature in typhoid fever, even below normal, and remaining so, indicates perforation of the bowels. Systematic examinations of the blood of typhoid fever patients will show no increase in the number of leucocytes at the onset of the disease, but rather a decrease, reaching its lowest point about the end of the febrile period. So soon as inflammatory complications develop, a marked increase of leucocytes will be observed, and this increase does not take place under any other known condition, and is considered a very important diagnostic sign of perforation. The only contra-indication to celiotomy in perforating typhoid ulcer is a moribund condition of the patient; as recovery in cases of local peritonitis complicating typhoid fever is not uncommon, celiotomy should not be resorted to in these cases. Should an abscess form, incision and

drainage is sufficient. The other variety of perforations above mentioned are of rare occurrence. The indications for celiotomy would be general septic peritonitis. The peritoneal cavity in general septic peritonitis is the same as an abscess cavity and should be treated as such.

Pancreatic and Intestinal Neoplasms, by Dr. Edward Borck.—Indications: Make a correct diagnosis as to the nature of the neoplasm, with or without an exploratory incision. Patient must be in good condition, prognosis favorable. Operate if practicable. Limitation: With the present knowledge of surgical technic, the only limitations are a condition that makes it impossible to remove a neoplasm, or if patient is already in a moribund state when seen. In reference to the pancreas, any neoplasm may be removed, provided the continuity and function of the main pancreatic duct can be preserved.

Diseases of the Appendix, by Dr. A. H. Meisenbach.—1. Simple catarrhal appendicitis should receive the proper medical treatment in the beginning of the disease. 2. A case of simple catarrhal appendicitis that is not materially benefited in the first 36 or 48 hours should be looked upon with suspicion; for perforation, abscess formation or gangrene may result, and therefore, operation be advisable, taking into consideration, however, the condition of the patient and all available data. 3. That every case of appendicitis, whose onset is marked by severe symptoms, should be operated on as soon as possible, for the severity of the symptoms indicate that it is likely to be either a case of appendicitis perforativa suppurativa or a case of appendicitis gangrenosa. 4. In cases of recurrent appendicitis, the appendix should be removed in the interval between attacks. 5. In the recurrent form it may be necessary to operate during an attack, this being determined by the character of the attack. 6. In the operations for appendicitis, especially the severer forms, a thorough appreciation of the pathology, and thorough command of the operative technic, is an important factor in the outcome of the case.

Hernia, by Dr. F. J. Lutz.—Herniotomy for the radical cure of hernia indi-

ated, although the function of the bowel is not interrupted, whenever the usefulness of the sufferer as a bread-winner is interfered with, or when frequently occurring strangulations place life in jeopardy. When strangulation occurs, and the function of the bowels is interfered with, taxis and celiotomy are the methods usually employed for the liberation of the herniated gut or omentum. Taxis may be, as a rule, successfully employed, and without the dangers incident to its use, while the true expansile hernial impulse exists. It should be done without an anesthetic, and continued for not longer than five minutes. When there is absence of hernial impulse, vomiting, constipation and putrefactive cracklings over the hernial tumor, taxis is contra-indicated and herniotomy (celiotomy) should be resorted to.

Colostomy, by Dr. Leon Straus.—The most signal advance in surgery of the rectum of late years is the doing away with the idea that intestinal obstruction is the only indication for colostomy. Inguinal colostomy is to be preferred to Kraske's operation in most cases of malignant diseases of the rectum. Colostomy is indicated in syphilitic ulceration of the rectum, especially where there is a close stricture.

Diseases of the Fallopian Tubes, by Dr. F. D. Mooney.—In acute inflammatory diseases celiotomy is contra-indicated, unless the conditions existing are such as to immediately endanger life. Catarrhal salpingitis, with open infundibula, can usually be relieved without operation. Treatment directed to the improvement of the condition of the endometrium is indicated. When the disease frequently recurs, removal should be recommended. When the infundibulum is closed by adhesions, and the tube, or a portion of it, is in such a condition that it can be restored to its normal state, it should be preserved. Tubes which are, or have been, largely distended, and when tortuous, should be removed. No other treatment is efficacious. Aspiration, incision and drainage, etc., are only indicated when it is advisable to gain time, in order to get a patient in condition for laparotomy. Always operate when tubercular deposits are existing or strongly suspected.

The Ovaries, by Dr. L. H. Laidley.—The indications and limitations of celiotomy in the treatment of the diseases of the ovaries are dependent upon two conditions, the general condition of the patient, and the local character of the disease. If the pathologic condition is one of degeneration, inflammation, or neoplasm, impairing the health, or threatening the life of the patient, celiotomy is indicated. This serves the double purpose of securing a better and more correct diagnosis, as well as providing the only way for the proper treatment of such cases with experience, common sense and a cultivated tactus eruditus. By having a knowledge of the usual conditions met with in the diseases of the ovaries, few mistakes will be made by the careful and trained surgeon, and none that can not be corrected by the skilled operator. The limitations are few, found in the advanced stages of nephritis, tuberculosis, cancer in any other organ, or any other wasting disease that may be expected soon to put an end to the patient's life.

Cesarian Section, by Dr. B. M. Hypes.—So many and varied are the factors entering into each case that no "hard and fast" rules can be formulated as a universal guide for the operation of Cesarian section. The indications and limitations of this operation have been greatly extended with recent advances in surgery and obstetrics. The indications may be *absolute* or *relative*. They are absolute when fetus can be delivered by no other method, *i. e.*, extreme pelvic contraction, bony growths and soft tumors, stenosis of vagina, grave accidents in labor and sudden death of mother. In fine, any condition that would prevent natural or minor method of delivery would justify Cesarian section, in the interest of both mother and child. Relative indications bring up the comparison of symphysiotomy, induced premature labor, craniotomy and Cesarian section, and decide as to which is best adapted to each particular case. Pelvimetry and the comparison of relative size of fetus and pelvis furnish very important evidence in reaching a conclusion. Craniotomy is inadmissible on living child. The mother or her representative should be consulted, and

should acquiesce in the operation performed. Cæsarian section should be performed upon sudden death of the mother, and upon women certain to die, when conditions favor it. The operation, to be most successful, should be elective, and should be performed prior to exhaustion and attempts at other inappropriate methods of delivery. Physicians practicing obstetrics should be conversant with pelvimetry, and be capable of properly diagnosing the existing abnormality.

Ectopic Pregnancy, by Dr. J. W. Smith.—1. All forms of ectopic pregnancy are originally tubal, antedated by a diseased condition of the genitals. 2. The life of the woman is the only consideration, first and last. 3. Celiotomy is the only measure for any form, at any time, advantage, of course, being taken, when possible, of the most opportune time. 4. Celiotomy offers a high degree of safety, entire absence of disturbance, both from fetal and diseased genital members, and is the only measure offering such happy returns.

Exploratory Celiotomy, by Dr. J. Y. Brown.—Modern methods of diagnosis, and a better understanding of the pathology of abdominal and pelvic lesions, have greatly reduced the indications for exploratory celiotomy. Accurate diagnosis in all cases is impossible, but, in the hands of men skilled in modern methods and familiar with pathology, a diagnosis sufficiently accurate for all practical purposes can be made in 95 per cent. of cases. In pelvic lesions exploration through the vagina is preferable to abdominal incision.

The axiom of Tait that "wise men look, and fools know" is very largely true, but the wise man should have a fair idea of what he expects to find before exploring, and should be thoroughly prepared to deal with the conditions found. Gun-shot wounds, and the various forms of intestinal obstruction, frequently present great difficulties of diagnosis; in cases of this character, prompt exploration is urgent.

THE PATHOLOGY AND INTER-RELATION OF VARIOUS MANIFESTATIONS OF CHRONIC INFLAMMATION IN THE NOSE.*

Chronic inflammation of the nasal mucosa is a slow process, modified in a hundred ways by external and internal influences, by climate and occupation, by systemic dyscrasie and racial peculiarities, by local configurations and concomitant lesions, by sex, and by age. Its clinical manifestations are usually considered under many different heads. Nasal polypi and polypoid degeneration, ethmoiditis, sinus inflammations, hypertrophic rhinitis, vascular hypertrophies, bony cysts of the middle turbinate, spurs, and deviations were merely manifestations of the same process modified by fortuitous circumstances and differences in the configuration of different regions and in the structure of the mucosa and its underlying cartilage and bone. Attention has been riveted so intently first upon one clinical division

and then upon another that we have in some instances got a little at sea because we have not kept in mind the pathology which underlays them all, bound them together, and furnished missing links in their etiology. Vasomotor excitability, he said, was an indispensable factor, which arose from local or reflex or systemic causes, such as coryza or dust, dyspepsia and constipation, rheumatism and gout, and supplied the over-nutrition to the tissues which led to the changes in the mucosa.

In the region of the inferior turbinated bone, especially at its posterior and inferior border and at the adjacent parts of the septum, there was a thick vascular mucous membrane covering a well-defined peristemeum, which in turn covered a firm bony structure. The walls of the venous sinuses and the surrounding stroma were well supplied with unstriped muscular fibres.

Regarding the hypertrophies at the pos-

* DR. JONATHAN WRIGHT before the Laryngologic Section of the New York Academy of Medicine. *New York Medical Journal*.

terior ends of the inferior turbinated bones, which present a mamillated or mulberry surface, it is possible to trace all degrees of this furrowing of the surface up to a condition which, to the naked eye, bears a close resemblance to true papilloma. Doubtless there was a continuous growth of fibrous tissue in these ridges and processes, but evidently the form it took was dependent largely upon the dilatation and collapse of the erectile tissue. Normally, the fibrous tissue was largely made up of curling fibres, which had the power of diminishing the volume of the mass regularly when vasomotor contraction drove the blood out of the venous sinuses. In the unstriped muscular fibres scattered through this stroma there was a powerful adjuvant to this physiologic action. In a posterior body distended by blood, when there was no fibrous hypertrophy present, a smooth surface would be seen. In a few minutes vasomotor contraction might suddenly occur and the engorged tissue collapse. Then in the post-nasal mirror little rugæ would be seen on the surface. Even in the normal state a slight folding occurred.

When the fibrous hyperplasia had decidedly advanced, it would be found that the elastic fibers had lost their characteristic appearance; that they had been replaced by or metamorphosed into long, straight ones of low organization; that the unstriped muscular tissue had largely disappeared; and that the surface epithelium was somewhat metamorphosed, and the number of its layers was increased. After these changes began collapse became more or less incomplete, but the furrows grew deeper by reason of the growth of the fibrous tissue. The vascular dilatation increased in the deep vessels, but near the surface, on account of the constricting action of the pressure of the growing fibrous tissue, the smaller network became more or less obliterated, and there was an inert mass blocking up the inferior meatus. This result of chronic inflammation might be observed in the nose wherever there existed the so-called erectile tissue. In places on the septum, varying in different individuals as to amount and exact locality, the erectile tissue might also frequently

have been found, as well as upon the inferior turbinated bone.

Dr. Wright called attention to another important observance in studying these vascular hypertrophies, which was that the tissue in the large growths of long-standing cases looked, *in situ*, translucent and watery, the color being either pale or dark red. This, he said, when snared off, would be seen to exude a watery secretion as it contracted. On microscopical examination, edematous areas, similar in structure to the mucous polypi of the middle turbinated, would be seen. These areas were usually observed at the periphery of the lobules, close beneath the epithelium. These were links in the pathology which connected vascular hypertrophies of the inferior turbinated with edematous conditions of the middle turbinated bone, the varying preponderance of the different manifestations of chronic inflammation depending upon variations in the anatomy of the mucosa.

There were also certain differences in the character of the hyperplasia and degeneration of the fibrous tissue of the mucous membrane, according to the age of the patient. In people past forty-five it would be seen that the fibrous-tissue fibres were losing their outlines, and that large areas of hyaline-looking or structureless material were appearing as the result. The older the patient the more marked was this appearance. The same change was seen also to some extent in younger subjects of low vitality.

Bone disease, said Dr. Wright, was usually more frequently observed and more pronounced in the ethmoid and its process, the middle turbinated bone, than elsewhere, but in extensive disease of the mucosa of the inferior turbinate osteophytic deposits were found along the lower border of the bone when small portions were removed surgically, and they might frequently be observed in anatomic preparations of the skull, being evidently due to the involvement of the periosteum in chronic inflammation. In ordinary echondroses of the septum, which should be carefully distinguished from dislocations and curvatures, there was nearly always thickening of the mucosa which covered them. Microscopically, there

were evidences also that the inflammation had spread through the mucous membrane to the perichondrium, and that there was an analogous deposit of cartilage cells. These cartilage cells had nearly always changed, to some extent, to bone. On the bony septum in exostoses there was a similar proliferation of bone. Dr. Wright was convinced that septal deviations and curvatures were due, to some extent, to this supernutrition causing growth in the vertical and horizontal diameters of the plane of the septum.

Not only was vasomotor excitability a connecting link in the etiology of the fibrous and vascular hypertrophies of the lower nasal regions, but it also played an important part in the production of edematous nasal polypi. In hay fever the vasomotor derangement originated largely in some vice of the central nervous system. So far as he has been able to study the history of these cases, the author stated, chronic nasal occlusion rarely antedated the first attack of hay fever. Nasal polypi, when present, were rarely found until the patients had suffered from two or three attacks, usually not until after many seasons. A prominent symptom of hay fever was the watery nasal discharge during the attacks. This serous fluid came directly by transudation from the dilated blood-vessels. The mucous membrane was water-logged; it was pale, though swollen and sodden. If it was examined under the microscope, Dr. Wright said, we should be struck with the close similarity of the structure to that of the ordinary nasal polypus.

When the autumnal frosts came the condition subsided, and in many cases a fairly healthy mucosa was presented; at least there was no suggestion of polypi in many of them. The vessels were able to regain their tone and to hold within their walls the serum of the blood. After a number of attacks they gradually lost their power. After the vasomotor excitement subsided a little, edema still remained. This increased, and, together with a few other changes of the normal structure, such as the decrease in the number of the glands, thickening of the epithelium, etc., there was a gradual development of an edematous rhinitis, and the

formation of pendant areas which were called mucous polypi. In many cases of hay fever Dr. Wright believed this to be the sequence of events. In how many this occurred he could not state positively, but certainly it did not in all. He believed that the nasal polypi which often accompanied hay fever were in many cases neither the cause of it nor a coincidence, but the result of it.

So far as he knew, there existed in rhinologic literature no satisfactory report of a case of nasal myxoma in which the pathologic histology established the diagnosis. He had examined nearly a hundred of these growths microscopically. Others in the aggregate had examined thousands. Hence he believed we were justified in thinking that true myxoma did not occur in the nose.

The mucous membrane on and above the middle turbinated bone was less vascular than in the region of the inferior; the epithelium was more delicate and was supplied with cilia. There was not so much fibrous tissue, and the periosteum was less dense. The bone itself was made up of delicate branching plates lined on both sides with mucous membrane, the deep layers of which in places communicated with one another through spaces in the bone.

In a previous paper dealing with the vascular mechanism of the nasal mucosa, Dr. Wright had shown how the deep radicle arteries and veins entered the nasal chambers together through the same bony canals, so that vasomotor dilatation of the artery not only let in more blood to the mucosa, but, by encroaching on the neighboring vein, compressed it and thus obstructed the venous return. A permanent dilatation of the artery by vasomotor paresis, usually dependent upon chronic inflammation, brought about a condition of engorgement of the deep sinuses in the erectile tissue of the inferior turbinated body.

In the mucosa of the middle turbinate, however, the same condition was favorable to the exudation of the watery parts of the blood from the thin-walled peripheral vessels. The formation of inflammatory deposits of a cellular or fibrous or bony character would produce the same result,

for the walls of the deep veins, though sparsely supplied with muscular fibres, were thin and very much more compressible than the thick, muscular walls of the arteries. In the normal mucous membrane in a young animal or in an infant there was strong evidence that more or less of this exudation went on normally. The nuclei of white cells, without the cell bodies, were washed through or between the endothelial cells of the vessels into the stroma, and through the epithelial lining of the glands and of the surface. In places the cilia of the surface epithelium was crowded with these nuclei, which were really only cellular detritus.

In the nose the gelatinous mucous polyp was produced by inflammation only when some one or more of the causes mentioned brought about chronic congestion of the parts and the effusion of an abnormal amount of serum. Some hyperplasia of the stroma, some degenerative changes in the glands took place, and the surface epithelium occasionally became thickened and metamorphosed into flat cells in places. All these changes not only prevented the reabsorption of the serum, but, to some extent, prevented it from exuding at the surface.

The bone normally contained abundant areas, which were filled with delicate connective tissue, producing the osteoblasts and osteoclasts which lined the bone. In some places small cavities had been shut off from communication with the surface, and these tiny cavities, analogous in the middle turbinate to the larger bone cells of the body of the ethmoid, were lined with cylindrical ciliated epithelium. From the general character of the normal ethmoidal structure we might understand the changes which might occur in chronic inflammation. In the first place, the bone tissue might be greatly increased in amount by the excessive activity of the osteoblasts. Accompanying this, almost invariably, some rarefaction was caused by the activity of the osteoclasts. When this process occurred in the walls of these small bony cavities an increase in their diameter followed, the osteoblasts depositing bone salts and forming bone cells, and the osteoclasts along the inner surface absorbing bone salts and disintegrating bone cells. His-

tologists, said Dr. Wright, stated that osteoblasts were converted into osteoclasts, and, inversely, that osteoclasts might be converted into osteoblasts. They were cuboidal in shape and evidently grew from the connective tissue. These patches of connective tissue lying in the bone and communicating frequently with that external to it were known ordinarily as the Howship lacunæ of bone.

Dr. Wright thought it was a curious clinical fact, of which histology had as yet given no adequate explanation, that the very great majority of cases of atrophic rhinitis occurred in young women. It was also a curious fact that pure fibroma in the naso-pharynx was almost exclusively found in young men. These facts were analogous to those observed in the bony cysts.

Nearly all the cases of bony cyst of the middle turbinate had occurred in women. The reason for this influence of sex in the etiology could probably be discovered only by keeping the pathology constantly in mind. The pathologic process might not only enlarge a small closed cavity in the middle turbinated bone, but also act in the same manner in the prolongations into it of the cavities from the body of the ethmoid. Dr. Wright exhibited specimens in which communication with the cells of the body of the ethmoid was observed, and the question might naturally arise, he said, as to whether this was not always the case. Usually only a portion of the cyst wall was removed, and it was impossible to assert that a communication did not exist with the cavities above.

In regard to the serous edema of the mucous membrane, it naturally followed that the effused serum tended not only to infiltrate the subepithelial stroma, but to extend through it and with it into the substance of the bone, and, by pressure, to cause dilatation, absorption, and granular disintegration of the bony structure. Then there was the clinical condition of ethmoiditis. Woakes's error lay in supposing that the inflammatory process originally began in the bone, in calling the bony changes a necrosis, and in terming the edematous structure myxomatous, but to him rightly belonged, as Hajek urged, the credit of having drawn attention to the importance

of these bone changes, and of the proper understanding of much that was confusing in nasal pathology. This process was usually confined to the middle turbinate, but sometimes it extended higher up into the cells of the ethmoid body. Secretions there became infected and purulent, and there was the dangerous, but fortunately rare, form of inflammation which was known clinically as empyema of the ethmoid sinuses. It was this clinical difference in the two sets of cases, Dr. Wright said, which had led to the apparent difference in the experience of observers as to the frequency of the occurrence of purulent ethmoiditis. It was frequently observed in the middle turbinate, but it was much rarer in the ethmoid sinuses than purulent inflammation of the maxillary sinus. It was this occurrence of serous infiltration in inflammations of the mucosa

of the middle turbinate region which caused the frequent association of ethmoiditis, mucous polypi, and cysts of the bone.

Chronic inflammation with edema might spread to the mucosa of the other sinuses, and by obstructing their outlets cause a purulent infection. On the other hand, purulent inflammation might start first in the frontal or maxillary sinuses, and by its ichorous discharges set up an inflammation of the intranasal mucosa around the hiatus semilunaris, with the formation of polypi. It was known from clinical observation that nasal polypi would promptly disappear from the nasal chambers or cease to recur after removal when associated with empyema of the antrum, if the latter was drained by an opening from below. Finally, all the lesions mentioned were occasionally seen simultaneously in the nasal chambers of an individual.

SOCIETY REPORTS.

Stated meeting, May 12, 1897.

The President, Dr. JAMES TYSON, in the chair.

Dr. J. MADISON TAYLOR, as Chairman, read the

Report of the Committee on the Health Protective Hospital for Contagious Diseases.

(See page 705.)

Dr. EDWARD ROSENTHAL read a paper upon
The Municipal Hospital of Philadelphia.

(See page 706.)

DISCUSSION.

Dr. J. MADISON TAYLOR called attention to two points that it is important to emphasize: One is, that after pretty careful thought on the part of a number of people, including the Board of Health, no place has been found better than the present site of the Municipal Hospital, both for the reasons given by Dr. Rosenthal so clearly, and for many other collateral considerations.

Secondly, the outfit and the place are small, the plant is inadequate in many particulars, and the older buildings are inferior in all ways.

The original building should be disinfected by fire, as it is saturated with ancient infection. The opportunities for access to this locality are good and there are many points about this situation for the Hospital that make it desirable to retain it. The important question is, What is the best thing now to do when modern changes are contemplated? The present site is about the best place for the purpose. Another thing is that there is always enough of scarlet fever and diphtheria in our city all the time to warrant a hospital for these diseases alone, and this is a proper place for such cases. Small-pox had much better be in some remote place such as Tinnicum Island, or if that is too remote then in a separate enclosure near the present one. Finally, there should be some adequately equipped place of isolation for the milder diseases that would work considerable havoc if they become severe, such as measles and whooping cough. That is a matter that will come up for immediate consideration in the future and will need considerable care.

Dr. BENJAMIN LEE presented the following communication:

Through the courtesy of a committee of the Board of Health of Philadelphia, and of Dr. William M. Welch, Physician to the Municipal Hospital, I have recently had an opportunity of inspecting the new Diphtheria Pavilion and Administration Building of the Municipal Hospital, and I desire to bear cheerful testimony to

the fact that in my opinion this building meets nearly every requirement known at the present day for a hospital for infectious diseases. The method of heating and ventilating by forcing pure, warm air into the wards at points high up in the walls and withdrawing it again by exhaustion at points near the floor, certainly leaves nothing to be desired in the matter of securing an ample supply of air at a proper temperature, without causing drafts upon the patients, its constant and ample renewal and its complete removal.

This is effected by means of a powerful steam fan in the cellar, and an electric fan at the terminus of the ducts in the upper story of the tower in which the plumbing appliances are placed; the fresh air being drawn through a lofty stack 50 feet distant from the building. It has been amply demonstrated that the thoroughly ventilated ward of a hospital affords a better opportunity for recovery than the sick room of the ordinary home, and especially of those of the poorer classes. It is a matter of observation that patients in the acute stage of smallpox, with high fever and delirium, after being a few hours in the purer air of a well-ventilated hospital, have experienced decided improvement, the pulse and temperature falling and the mind regaining its sanity. The painted and enamelled walls, rounded corners and impervious floors are admirably suited to prevent the retention of the germs of disease. The use of iron and glass in the furniture, wherever this is possible, is also an admirable precaution in the same direction. The private rooms for pay-patients are extremely cheerful and attractive. I am sure that no one who has seen them would object to having his child, or other relative, removed to one of them, if circumstances were such as to make the treatment of the case in the home a danger to other members of the family and the community. It is evident that those who planned and constructed this pavilion were actuated simply by a desire to assure practical results in the treatment of the patients, and the prevention of the extension of the disease, and that not a penny was spent on unnecessary architectural decoration. I can heartily endorse the statement of the efficient Superintendent of the Bureau of City Property that "in this building the city has received a dollar's worth for every dollar spent." It has been my duty to inspect many such buildings, and I can honestly say that I have nowhere seen any better adapted for their purposes in every respect. I was especially pleased to note the care that had been taken to provide pleasant and comfortable quarters for the nurses and other attendants. Certainly if any one is entitled to a comfortable sleeping room and a cheerfully furnished apartment in which her occasional hours of relaxation during the day may be passed, it is that devoted being, the nurse in an infectious disease hospital.

I desire to express my gratification at finding within the hospital enclosure a large pavilion appropriated exclusively to what are termed "mixed" cases; namely, of diphtheria and scarlet fever existing in one patient at the same

time, inasmuch as in this way those who are so unfortunate as to have received both infections into their systems are afforded a refuge. Otherwise, in the interests of those suffering from either disease alone, it would have been essential to exclude them. There is, however, still another class of patients of this description for which, owing to lack of funds, provision has not been made. These are the cases of mixed measles and diphtheria. It is sincerely hoped that City Councils will appreciate the necessity for a provision for this infection and will at the earliest possible moment provide a sufficient fund to erect a separate and distinct pavilion for such cases.

In this connection I beg to be allowed to remark that the State Board of Health has been so impressed with the mortality resulting from measles, which has commonly been considered so mild a disease as to be almost excluded from the necessity for legal restrictions, that it has just issued a circular for the object of impressing both on health-authorities and on the popular mind the importance of subjecting this disease to precisely the same restrictions as are now in force for the other contagious diseases.

Taking the entire group of buildings I doubt if any city in this country has a more complete and well-arranged hospital for the treatment of communicable diseases. This being the case, what necessity exists for the establishment of private pay-hospitals for the treatment of such affections? It is not probable that any hospital erected by private subscription will be more perfect in all its appointments or will afford more cheerful accommodations, even for those who have been accustomed to luxurious homes, than are found in the private rooms of this new pavilion. The necessity arises from two well-established facts:

First, that even with the new pavilion there is little more room provided than at the present time is required for the care of the city's wards, while the very limited number of pay-rooms would make it necessary to place the greater number of pay-patients, applying for admission, in the general wards; and secondly, that there exists in the minds of the community so deep-rooted an objection to making use of the charity hospital of the city as a refuge for the members of one's own family that the public never could be induced to make use of it to such an extent as would meet the objects which are in the minds of those who are favoring the establishment of such private hospitals.

Nothing is more remarkable in the relations of the public to the medical profession at the present time than the readiness that has developed within a comparatively brief number of years to avail themselves of the immense advantages afforded by hospital treatment, especially in the case of the surgical affections. It must have been observed, however, that the line is drawn with tolerable sharpness between private hospitals, pay hospitals, and almshouse or charity hospitals. This arises partly from a natural and praiseworthy spirit of independence, which makes people dislike to have it known

that their friends are in an institution which is supported out of the city's funds; and secondly, from the dread of contact with those belonging to a lower social class and who may be supposed to be of uncleanly habits.

I do not conceive that any amount of argument is going to uproot this deeply implanted horror of eleemosynary institutions. The only other solution of this problem, therefore, lies in the establishment of a number of comparatively small hospitals for the treatment of contagious diseases in different sections of the city, so that they may be easily accessible, especially adapted in every way for the treatment of such diseases in accordance with modern requirements, and with such careful provision for the purification by fire of all air which has once entered the buildings that the possibility of the transmission of disease beyond their walls shall be absolutely prevented.

I entertain no doubt that in a comparatively short time the public would begin to appreciate the opportunities thus afforded and to avail themselves of them. The advantages accruing would be:

First, a great diminution in the number of centers of infection.

Secondly, a great diminution in the period of domiciliary quarantine always so full of annoyance, vexation and loss.

Thirdly, the ensuring of the best possible conditions, both hygienic and therapeutic, for the recovery of the patient.

Fourthly, the great diminution of risk to other members of the household.

It is not necessary for this purpose to erect very large buildings and it would be folly to indulge in any excess of architectural display. The experience of the Board of Health of this city, as well as of those of other cities, amply demonstrates that such a system of hospitals as is contemplated could be constructed at no very great expense and it is presumed that once established and appreciated, they would support themselves and possibly prove paying investments.

In conclusion, I desire to offer the tribute of my admiration, however unworthy, for the devoted manner in which the present Physician of the Municipal Hospital has for so long a period discharged the responsible duties of the position.

DR. WM. M. WELCH said that many difficulties are encountered in the Municipal Hospital, the chief of which is the difficulty of obtaining money sufficient to provide what is required. A number of pavilions were recently erected, and they are in many respects very complete and satisfactory. The diphtheria pavilion, erected in 1893 and enlarged in 1896, is certainly well adapted for its purpose. It is indeed so complete in all its appointments that there is but little to ask for in the way of improvement.

The Main Hospital building, erected in 1865, has had nothing added to it since, and is very much in need of repair. It should be enlarged, modernized, and perfected. In some respects the wards are excellent: they are large, the ceilings high, the corners rounded, and they

contain large open fire-places, but they are not properly heated and ventilated. The bath-rooms and water-closets are inadequate and unsanitary. There are no rooms for pay-patients and no extra diet-kitchens. The only place available for preparing food for distribution is in the bath-rooms, and these are in the same apartments with the water-closets. The rooms for nurses and other employees are not sufficient, and most of these rooms cannot be heated because of the absence of chimney-flues. The needs of the hospital have frequently been pointed out, but it has never been possible to convince City Councils of their absolute necessity.

A recent census of the hospitals in this city shows that the Municipal Hospital occupies a place second only to the Philadelphia Hospital as to the number of patients under treatment. At the present time there are 312 patients in the various buildings; the daily average during the winter having been about 300. In order to accommodate this large number it is necessary to place two children in one bed in many cases, one in either end. This sounds worse, however, than it really is, for the beds are large and the children small. This condition of things should, however, not exist, and it would not if sufficient money were appropriated to provide what is needed.

The diseases in the hospital at the present time are scarlet fever and diphtheria. There are a number of mixed cases under treatment; that is to say, cases in which scarlatina and diphtheria co-exist. These are isolated and treated in a building known as the temporary hospital. Not infrequently the Loeffler bacilli are found in the fauces of well-marked cases of scarlet fever; and, on the other hand, the scarlatinal rash frequently occurs in well-marked cases of diphtheria. In the latter event the source of the scarlatinal affection is sometimes known, while at other times it cannot be ascertained. It not infrequently happens that the diphtheria-ambulance is sent for a case reported as one of diphtheria, but when the case is examined by the resident physician who accompanies the ambulance it is found to be one of scarlatina. This ambulance then returns to the hospital, and the scarlet-fever ambulance is sent for the patient. In spite, however, of all the care that can be exercised an atypical case of scarlatina occasionally finds its way into the diphtheria-wards, and the infection spreads. Dr. Welch's experience leads him to believe that there is a very close relation between these two diseases. Often both of these diseases are seen in the hospital at the same time, equally well marked in different members of the same family. These facts show how important it is that the hospital should be provided with ample facilities for separating not only the various infectious diseases, but also every possible form of co-existence of these diseases.

The hospital grounds should be enlarged. This can readily be done by purchasing the adjoining plot of ground to the south of the hospital. The acquisition of this land is neces-

sary in order to provide a place for the erection of a small-pox pavilion. If small-pox should occur at the present time it would be necessary to put the cases in a tent; and there is even no place where a tent could be located so as not to endanger the scarlatina and diphtheria patients now under treatment. The vast majority of patients suffering from the latter diseases are children, and many of them unprotected by vaccination. Hence, there would be great risk of the variolous infection spreading.

It is injudicious to treat small-pox patients in the same locality as patients suffering from other diseases, even though the various pavilions may be separated a reasonable distance from each other. There would be but little risk so long as the number of small-pox cases was small, but when the cases are numerous, it is necessary to employ a large number of nurses and other attendants, some one of whom at an unguarded moment, as may be safely assumed, will grow careless, even under the best management, and thus become the agent of spreading the infection. Dr. Welch is becoming more and more convinced every year that some other suburban section should be selected for a small-pox pavilion, and that the present buildings should remain indefinitely where they are for the treatment of diphtheria and scarlet-fever patients. This change would probably remove all opposition to the present location of the hospital.

DR. JAS. TYSON asked the question whether an ideal plant would involve a separate room for each case of infectious disease of this kind, or whether all could be treated in a common ward to as great advantage.

DR. WELCH replied that the risk of intercommunication of disease could in that way be prevented; but such a method would be quite impracticable in a large hospital.

DR. ROSENTHAL said that the only way to open the eyes of Councils to the necessity of extension and alteration of the Municipal Hospital is through experience, such as an epidemic of small-pox, or some other infectious disease. The failure of Councils to act in the matter has caused the Health Protective Association to undertake to secure the means to build a pay-hospital for contagious diseases. The diphtheria pavilion of the Municipal Hospital is in every way a most admirable place, and if there were a sufficient number of such buildings for cases of scarlet fever and diphtheria the projected new hospital would scarcely be necessary. The present situation of the Municipal Hospital can hardly be improved upon.

DR. H. AUGUSTUS WILSON read a paper upon **Portable Door Attachment for Applying Suspension.**

(See p. 710.)

AMERICAN ACADEMY OF MEDICINE.

The American Academy of Medicine held its twenty-second annual meeting at the Con-

tinental Hotel, Philadelphia, May 29 and 31, 1897. The program was as follows:

The Associated Duties of a Physician.

I. "The True Principles on which the Medical Profession should be Associated, and the Character of the Resulting Organization." Leartus Connor, M.D., Detroit.

II. "Physicians' Mutual Aid Societies." John B. Roberts, M.D. Philadelphia.

III. "The *Quid pro Quo*—Present and Future." C. C. Bombaugh, M.D., Baltimore, Md.

IV. "Are Physicians Up to Date? a Sociologic Inquiry." Charles McIntire, M.D., Easton, Pa.

V. "The Relation of the Physician to the Public Press." Solomon Solis Cohen, M.D., Philadelphia.

VI. "Some Relation of Author, Publisher, Editor and Profession." George M. Gould, M.D., Philadelphia.

VII. "Medical Reviews." Walter L. Pyle, M.D., Philadelphia.

VIII. "The Influence of a Liberal Education with Reference to Medical Ethics." Elmer Lee, M.D., Chicago.

IX. "The Organization and Support of Public Medical Libraries." George M. Gould, M.D., Philadelphia.

X. "Result of a Year's Endeavor to Lessen the Dispensary Abuse in the Rhode Island Hospital, Providence, R. I." F. T. Rogers, M.D., Providence.

MONDAY, MAY 31.

Annual Address by the Retiring President, J. C. Wilson, M.D., Philadelphia.

I. "The Relation of Alcohol to Preventive Medicine." J. W. Grosvenor, M.D., Buffalo.

II. "The Truth about Calomel." Everett Flood, M.D., Baldwinville, Mass.

III. "The Great Physician of the Revolution: A Doctor sans peur et sans reproche." A. L. Gihon, M.D., Medical Director, U. S. N., retired.

IV. "Where Shall We Put Up the Bars? A Plea for Preliminary Education." A. L. Benedict, M.D., Buffalo.

V. "Medical Education." George C. Hopkins, M.D., Brooklyn.

VI. "Farther Advances Needed in Medical Education." G. G. Groff, M.D., Bucknell University, Lewisburg, Pa.

Discussion: "The Relation of the College to the Medical School."

"The Side of the Medical School." Bayard Holmes, M.D., College of Physicians and Surgeons, Chicago, Secretary of the Association of American Medical Colleges.

"The Side of the College." Ethelbert D. Warfield, LL.D., President, Lafayette College, Easton, Pa.

"The Side of the University." William Pepper, M.D., LL.D., ex-Provost, University of Pennsylvania, Philadelphia.

Dr. Gihon's address was in behalf of the Rush monument fund. Dr. Grosvenor's paper was, almost confessedly, a temperance address. It elicited much discussion, most of the speakers agreeing with Dr. Grosvenor, and Dr. Didyma, of Syracuse, expressing the opinion that alcohol would be almost discarded as a therapeutic agent. Prof. Parvin said that he thought that the prevalence of drunkenness was largely due to unfavorable social conditions; that so long as men and women suffered, they would resort to something to deaden their realizations of suffering. Papers II., V. and VI. were read by title.

Dr. Bayard Holmes, in the discussion on "The Relation of the College to the Medical School," lamented the lack of endowment for medical colleges and hospitals, and said that he had found some hostility to the medical school on the part of college presidents, who rather advised their graduates against the medical course. Dr. Pepper and Dr. Warfield both advocated reciprocity between the college and the professional school. Dr. Pepper spoke especially regarding the poor results sometimes attained by A. B.'s in the medical college, and emphasized the importance of group-election of studies in the college, preparatory to the professional course. He believes that the man or woman should be ready for practical wage-

earning life by the age of twenty-four at the latest.

In the discussion, the opinion seemed to be quite evenly divided between a college course uninfluenced by the later professional work of the student, and the idea of having one course lead up to or form an integral part of the other. Dr. Hurd, of Baltimore, and the president, Dr. Wilson, emphasized the fact that the main loss of time in present educational methods, was in the primaries. Dr. Wilson said that three years could be saved before the child was thirteen or fourteen, owing to the repetition in the lower grades. Dr. Rochester thought that no attempt should be made to have the average student graduate in medicine before he was twenty-six or seven.

The annual reunion session was held at eight in the evening, the wives of many of the members attending the banquet.

The annual election of officers resulted as follows: President, L. Duncan Buckley, New York; vice-presidents, Dr. John B. Roberts, Philadelphia; V. G. Bowditch, Boston; Charles Denison, Denver; F. T. Rogers, Providence; secretary and treasurer, Charles McIntire, Easton; assistant-secretary, Walter L. Pyle, Philadelphia.

One hundred and two new members were elected.

PERISCOPE.

NEWS AND MISCELLANY.

A Recent Case of Hyperpyrexia is reported by Newton in the *Lancet*. The patient, a girl aged fourteen years, a pupil at a large school, complained during the evening of a general feeling of malaise. On awaking next morning she appeared to be very ill and was removed to the school hospital. Here the nurse was struck by her strange manner and appearance, and on taking her temperature was amazed to find that the thermometer registered 110° F. Thinking that there must be some mistake she shook the mercury down and again took the temperature in the mouth, and found that the instrument again registered 110°. Another thermometer was tried with the same result. The patient was put to bed and a large dose of antipyrin administered; and when seen by the physician, about three-quarters of an hour later, the temperature was below 101°, and the delirium had nearly passed off. The nurse had, however, kept the thermometer for the doctor to see. During the day the patient developed a slight attack of phlyctenular tonsillitis, and in forty-eight hours she was quite convalescent. About a month before this same child was attacked with the same complaint, the temperature on that occasion reaching 107°.

Remarkable results are reported to have been obtained in England by **Treating Wounds With Oxygen Gas**. Two kinds of micro-organisms are found in wounds, one kind being beneficent and the other injurious in its effects. Oxygen causes an increase of the former and a decrease of the latter, so that, according to a writer in the *British Medical Journal*, wounds treated with oxygen heal more rapidly and with less pain than by any other form of treatment.

The Treatment of Diabetes Mellitus to this date has been one of the most disappointing of all to the profession; all the more because of the ignorance of its pathology, unless it be due to a known traumatism, and hence a lack of knowing how the drugs used, such as ergot, opiates, arsenic, bromides, nervines, and the interdiction of starchy and sugary foods, can act on an unknown pathologic factor.

The strange part is the radical form the treatment in most cases assumed, especially the strictness of the diet prescribed, causing in nearly all instances, especially in the very young, destructive metabolism, a starvation, in fact, on account of withholding just what the patient craves, and forcing soja bread, gluten biscuits, and nitrogenous food upon them, a

procedure warranted only in the old and philosophic temperaments, who would get along with anything equally well.

The best authorities, such as Cantani, Pavy, Schnee, Saundshy, Purdy, and all clinical authors, recite the same tale of disappointment and death; yet they advise us to diet and drug, just as most of us do, and lose our patients all the sooner for it. It is advised that we employ good sense, where we are so much in the dark as to the pathology and etiology. Be less radical, and treat what we can see; the thirst with drinks, plain and acidulated; relieve the constipation with mildest methods. Give only such drugs as agree, and let our patients eat what they will, rather than starve them.

The treatment resolves itself into a matter of humanity, rather than harsh measures of dieting and drugging, since all such means have proved fruitless, and, if beneficial, only for a short period. This course is especially recommended in the young, who usually die soon, and treatment is of but little use. Why sugar is manufactured in this disease in excess, and why it is poison to the economy in greater quantities than three per cent., is still a fact unknown to us.

We are to remember the mistakes of our forefathers, of starving fevers and withholding water, and rank the radiant treatment of diabetes with them. Let us above all things be humane to our patients and not starve them.—*Health.*

Ureteral Anomalies Are Comparatively frequent, says M. Jacques (*Presse Medicale*), explainable by the successive modifications the duct undergoes in development. Two or three times in a hundred autopsies the ureter had been found divided at its upper end, which, he said, was but an exaggeration of the normal division of the pelvis of the kidney. The complete division with double vesical anastomosis was infinitely rarer, especially when this disposition was bilateral. Such a division of the ureter, congenital, complete and bilateral, had been found in an elderly woman who presented symptoms of a visceral tuberculosis of long standing, without any appreciable alteration, moreover, of the urinary system. On the right and on the left there were two distinct renal pelves. The two ureters on the left side opened side by side into the bladder like a double-barreled gun. On the right side one of the ureters was inserted in the usual place, the other midway between the opening of the first and the vesical meatus. The uterus was atrophied, fibromatous and cystic.—*New York Med. Journal.*

The transparency of bones to X-rays in cases of tuberculous disease is considered by T. E. Espin, M.A., in the *British Medical Journal*, the following cases being cited: December, 1896, a youth of 16 was brought to me with a locked wrist. A year previously he had run his arm against a wall, and apparently sprained

it. This came right, but about eight months afterwards trouble set in, and gradually increased till the use of the wrist was lost. Placing the wrist before the fluorescent screen the bones of the carpus were ill-defined, and the ulna and radius, metacarpal bones, and phalanges abnormally transparent. When the two wrists were placed side by side the difference in transparency was very remarkable. Not only are the bones of the carpus diseased, but the lack of contrast due to the transparency of all the bones is remarkable. The case is undoubtedly tuberculous. The point was an interesting one, and I anxiously waited for another case to settle the question as to whether not only the bones attacked by disease were transparent, but the whole of the bones in the immediate neighborhood.

Last week a young man came to me with a tuberculous knee. He had part of the radius of the left arm taken out a year ago, and had had a tuberculous abscess as well. He was thoroughly examined, and all the bones of both arms and legs were found to be abnormally transparent. There seems, therefore, good ground for believing that in cases of tuberculous disease of the bones there is an abnormal transparency not only in the part affected, but in all the bones of the neighborhood.

In hip-joint disease there is usually a tubercular history in the family, and a pre-tubercular stage present. The disease begins insidiously, develops slowly, and presents the symptoms of a low grade of inflammation, subject to exacerbations resulting from increased irritation from undue use of the joint, or changes in the weather. Pain is almost never felt in the joint itself, but on the inner side of the knee, leg, or ankle. A limp, not marked, not constant, but coming and going at first, but later becoming established, is significant of tubercular disease. Atrophy appears early and may be the only positive sign at the first examination. Err on the safe side and watch such a case. Muscular spasm is also an early symptom. It may not be marked, may limit the motions in only one or two directions, but when present is a sure indication of hip-joint disease.—*Archives of Pediatrics.*

A young and enterprising newspaper, the London *Daily Mail*, recently gave an interesting account of Richard Napier, who died in the year 1634, and who was famous alike as priest, astrologer, and physician. In his youth he was a pupil of the notorious Dr. Forman, who was little better than a quack, and who thought young Napier a dunce. Of the latter it is said: "His private life was exemplary, but he broke down once in the pulpit and would never preach again, but paid a substitute to do so for him. He obtained a license from the Church to practice as a doctor, and his patients were numerous, and some of them great personages." "He did," says an old biographer,

"converse with the angel Raphael, and prayer seems to have been one of the favorite medicines in his pharmacopeia. A large part of his professional income he devoted to the poor." This curious exponent of medicine at the beginning of the seventeenth century was a master of magic arts and faith-healing as applied to medicine. Sooth to say in those days it was open for any man of moderate attainments readily to acquire the slender stock of scientific knowledge that appertained to the physician of the time. So great was Dr. Napier's piety that it is recorded of him that his knees were horny with frequent praying, and that he died in the attitude of prayer. In the parish register he is described as "the most renowned physician, both of body and soul."—*Med. Press and Circular*.

How to Avoid Taking Cold.—The *fin de siècle* toilet is not complete without rinsing the mouth and spraying the nasal passages and the throat with an antiseptic solution night and morning. By these means the upper air passages are kept in an antiseptic condition, unfavorable to the development of germs, and disease is prevented. G. Lemoine, in the *Nord Méd.* of February 15th, states that numbers of persons by these simple precautions have passed through the winter and rainy spring without once catching cold, although they had previously been extremely sensitive, and troubled with severe colds much of the time. He recommends to rinse the mouth with a glassful of fifty grams Labarraque's solution mixed with one liter of water, or the following: Thymol, 0.50 gram; alcohol, 20 grams; water, 1 liter. With an ordinary toilet atomizer the nasal passages and upper part of the throat should be thoroughly sprayed with some solution like the following: Phenolsalyl, 0.50 gram; chlorid of sodium, 3 grams; distilled boiled water, 500 grams. He adds that the teeth should be well brushed, and the fingers never put in the mouth or nose. A few menthol drops should be carried in the pocket and dissolved in the mouth occasionally. He concludes with the remark that a friend of his has always succeeded in breaking up a cold in the early stages, by taking during the first day four to six capsules or pills of essence of turpentine in addition to the rinsing or gargling and spray, with a glass of purgative water the next day, followed in a few hours by a 0.50 centigram of quinine.—*Journal Am. Med. Ass'n*.

Antiseptic surgery has effected a reduction in cases of nodal or bursal pain, says Golding-Bird, in *Guy's Hospital Gazette*. There is no doubt that the patient's personal equation largely enters into the question. Many people seem to have no "inhibitory" power over their feelings; consequently it has been the fashion to class such cases together as "hysterical," whether the subject be male or female. I consider that antiseptics have helped to alter this state of things, and the use of them has given

"hysterical" people their character again; for the surgeon, without risk, explores the seat of pain, and at times drops upon a cause he never suspected. A. B., female, aged thirty years, nurse from a provincial hospital, was last year a patient in Guy's, suffering a great deal of pain in her hip without obvious cause. She was not of the hysterical type. Four months before admission the patient had entered a room during the night while a portion of the flooring was raised for repairs. She had fallen with one leg through the floor and had bruised her hip severely. She went on with her work, but at last persistent pain made her seek hospital treatment. Her hip was flexed, she had spasmodic pain in thigh, and had to take morphia. There was no limitation of movement. When first seen as out-patient the diagnosis of hysterical hip was given, because passive movements became greater in amplitude when the patient's attention was diverted, and because nothing objective could be discovered. Patient was examined a fortnight later by the surgeon, who confirmed the diagnosis so far that the movements were all perfect. In this case there was nothing wrong with the joint, and no swelling over it. It is true that there was a certain amount of tenderness in the groin, but this was totally unconnected with the movements of the hip-joint. The great trochanter was not thickened, but on its outer side I hit upon a tender area of the size of a half-penny, which was exquisitely painful and gave a creak on rubbing. This left no doubt in my mind, and I diagnosed bursitis under the gluteus near its insertion. The treatment available was either counter-irritation or operation. The latter method was chosen, and making an incision over the tender spot, I entered the bursa, which was found to be large and spread out under the gluteus maximus. This was scraped out and irrigated with perchloride and closed up again. Immediate union was obtained and patient was entirely free from all pain, and seemed, on her discharge, quite cured. With regard to the question of connection between bursal and local or nodal pain, it is interesting to note a point on the history of osteomata, which, as you know, are found commonly on the long bones, as the tibia and femur in positions corresponding to the epiphyseal lines. A boy will be brought up exhibiting an osteomata, which his mother will declare has only existed for four or five days, whereas it is more likely to have been present as many years. On manipulation, you will probably get the characteristic creak on rubbing the top of the boss. Whenever a bursa becomes developed on a prominence pain begins synchronously, but osteophytes may grow from the femur under the vastus internus, and may attain a very large size before there is pain; and this, when it comes, is either due to over-stretching of fascial coverings or the appearance of a bursa. Counter-irritants will have only a temporary effect in these cases, and the best treatment is to cut down and remove the tumor.—*Journal Am. Med. Ass'n*.

Massage in the treatment of skin diseases encourages the circulation, induces more active nutrition, and materially assists in the removal of diseased tissues, infiltrations and effusions by increasing molecular changes by means of mechanical stimulation. As usually performed, however, it is in many cases an unpleasant duty, and consequently seldom carried out so regularly or thoroughly as it ought to be. I have found that in a great many cases the massage can be sufficiently well performed by using an india-rubber roller instead of the hand, thus avoiding unpleasant contact with the skin. I have now recommended this method in skin cases for some time, and find it answers admirably. It is easy of application, and can be applied largely by the patient, though the back must be massaged by some other person. The roller I usually recommend is the ordinary roller used in photographic work, and there are others made which act equally well.

Another method of stimulating the skin in isolated patches is by the use of a blunted Volkmann's spoon or by a curette, both of which instruments I have used with benefit. This method, however, is best applied to the face and neck, and can only be performed by the surgeon. I have found it of great value in obstinate cases of acne and psoriasis and localized indurations.—*Tibbles*.

In the February number of the *Johns Hopkins Hospital Bulletin*, Dr. T. C. Gilchrist furnishes a tabular summary of twenty-three cases of skin lesions produced by the X-rays all that he was able to find in current medical literature.—*Atlantic Medical Weekly*.

Less Restricted Diet in Typhoid.—If the typhoid patient has a craving for solid food, is genuinely hungry, and has not a dry tongue, lips or teeth, I believe the rule of withholding solid food may be broken, not only without harm, but rather with benefit. The principal danger to be apprehended is perforation, and I do not see that the causes which lead to it can be avoided by the giving of liquid more than solid food,—the ordinary processes of digestion convert solid into liquid food before it reaches the seat of perforation. The majority of cases die from cardiac failure, lung complications, and all the other devastating effects of general infection, against which the patient can set only such powers of resistance as he possesses, and which will be more or less effectual, according as his general nutrition is maintained by food and the other effects of the wear and tear of the disease are diminished by all means possible. There is in the treatment of typhoid fever too great a tendency to treat the intestinal lesion at the expense of the individual, or if not that, to make the temperature chart the sole arbiter of our practice.

In thirty-one cases treated on this principle I lost only three, and these could not take solid food. True relapse occurred in only two cases.—A. G. BARRS, in *British Medical Journal*.

GOVERNOR ADAMS, of Colorado, has signed the bill prohibiting the sale of cocaine without a written prescription from a licensed physician or dentist.

Twelve years ago a married woman, aged sixty-seven years, was roused about three o'clock in the morning by violent pain in the eyeball, accompanied by vomiting, great prostration, and loss of perception of light (*glaucoma fulminans*). A surgeon was called in, some drops were used, and general directions given, but no operation was suggested, and the patient went on from bad to worse until the eye was completely lost. Three months ago the left eye was attacked during sleep, with precisely the same symptoms—pain, vomiting, prostration, and loss of perception of light. Notwithstanding her bitter experience with the right eye, similar treatment was adopted for the left for three weeks. I then found the eye-ball stony hard, the cornea steamy, the iris muddy, the pupil dilated to a rim, and the patient profoundly insensible to the most brilliant light. I immediately excised a large piece of iris (about a fourth), taking care to establish a filtrating cicatrix, an operation which was exceedingly difficult; but on its completion the painful symptoms ceased as if by magic, and sight was gradually restored, so that she can now with a little trouble read newspaper type, without glasses distinguish letters an inch long at twenty feet, go about by herself, and manage her own affairs.—*Taylor*.

It is estimated that the death rate of the world is sixty-seven a minute and the birth rate seventy a minute, and this seemingly light percentage of gain is sufficient to give a net increase of population a year of almost 1,200,000 souls.—*Atlantic Medical Weekly*.

Excessive Inflammation from Vaccination.—Now that direct calf-lymph vaccination is generally advocated, and it is admitted that inoculation from this source is commonly followed by more severe local and general results than arm-to-arm vaccination, it may be well that a means of cutting short the inflammation should be known. Should the vaccination postules on the twelfth or fourteenth day tend to become confluent while the inflammatory areola tends to spread beyond the usual limits, the glands in the axilla to enlarge, and the arm, perhaps, to become edematous, I would suggest that the area of the pustules should be powdered over with iodoform, and a sterilized dry pad be applied to keep the powder in position and the pustules from friction. In this way the process is completely checked in twenty-four hours. The pustules dry into a cake, the redness subsides, the glands decrease, and the edema of the arm rapidly disappears. This is in every way preferable to hot fomentations and antiseptic moist applications which, apart from the difficulty of applying to an

infant, involve the healing of open wounds.—
CLEMENT LUCAS, in *Med. Age*.

Transillumination and Maxillary Abscess.—One ought not to place too much reliance on transillumination in arriving at a conclusion as to the presence or absence of pus in the maxillary antrum. I saw a patient recently who had the usual symptoms of this condition, and in whom the very dark shadow under the orbit was most marked. I made the usual opening, by means of a drill, through the alveolus, and syringed out a good quantity of pus. About six weeks after the operation, the patient came to me nearly well, with very little or no pus coming out of the nose on syringing through the opening in the mouth, and with nearly complete absence of all the other symptoms from which he had previously suffered. I put a Voltolini lamp in his mouth, and, to my astonishment, the shadow was just as dark and just as extensive as it was before the operation.

Does this mean thickening of the mucous membrane or of the bone, or (which seems to me to be improbable when I remember the exceedingly favorable course of the case) the existence of thick pyogenic membrane? Perhaps other rhinologists have had a similar experience.—BARON, in *Med. Age*.

A MASSACHUSETTS man who sent a lock of his hair to a quack for diagnosis was informed that he was suffering from an ovarian tumor.—
N. W. *Lancet*.

Dr. John B. McGee gives some notes on the nitrites in the *Cleveland Medical Journal*. Lauder Brunton first used the nitrites thirty years ago in angina pectoris. The official salts are amyl and sodium. Their effect is prompt. Nitro-glycerin has taken the place of most forms of the nitrites and its action is so quick that it can usually be given by the stomach. Small doses stimulate the respiratory center and its use relieves spasmodic asthma, probably by relaxing the bronchial muscular tissue.

When it is required to estimate the chlorides in a water, 70 c.c. are placed in a glass cylinder and a soloid of chromate of potash (indicator) added, which is easily crushed by the end of a glass rod, so that the contents readily dissolve when the water is stirred. This done, a soloid of nitrate of silver is added in the same way. If no red coloration is produced, more soloids are added until the liquid remains red when well mixed. This indicates the end of the reaction, and each soloid used corresponds to two grains of chlorine per gallon. Further examinations—in regard, for instance, to the quantity of nitrites, nitrates, free ammonia, and even hardness—are conducted in the same way, while similarly the presence of objectionable metals can be detected and a measure of the organic impurity of the water made, judging by the amount of oxygen absorbed. This

is done by adding to 70 c.c. of the water until a faint and permanent pink appears, soloids of permanganate of potassium, each of which corresponds to 0.10 grain of oxygen absorbed by the organic matter in one gallon of water. A certain amount of care and discretion, of course, must be exercised in certain cases; but, as Doctor Thresh has satisfactorily shown, this method gives results which compare very favorably with the ordinary methods of analysis, which occupy much more time and involve the use of more complex apparatus. The introduction of this simple and approximately accurate series of processes should prove a valuable aid in the sanitary service.—*Lancet*.

A ROSEOLUS rash closely resembling that of scarlet fever is seen occasionally in septicæmia, diphtheria, malaria, nephritis, autointoxication from bad food, as well as after taking quinine, copaiba and many other drugs.—*Atlantic Medical Weekly*.

A child said to be suffering from scarlet fever was seen October 18th, by Dr. Stevenson. Neither pyrexia nor angina was present. There was a rash covering the neck, the chest, most of the back, and the abdomen down to the level of two inches or so below the umbilicus. It had a remarkable resemblance to the rash of scarlet fever, showing a uniform pink ground dotted thickly over with scarlet points. At the upper and lower edges of the eruption there were isolated scarlet points. There was no rash anywhere else. The limited area of rash and its almost sharply defined upper and lower edges were suspicious, and I asked the mother if the child was wearing new flannel. She said not, but she informed me that she had washed the child's woolen undervest with water to which some paraffin oil had been added, and on examination the garment in question had a strong odor of that oil. The rash quickly faded away, there was no desquamation, and although there were two or three more children in the house who had never had scarlet fever, no more cases of rash occurred. The house was also a very insanitary one, so that I think there can be little doubt that this was a case of artificial rash caused by irritation from paraffin oil.—*Lancet*.

Farmer.—I want a box of Blank's pills.

Clerk (reaching up to the shelf).—Yes, sir.

Farmer (hastily feeling in his pockets while his hair rises).—Gosh! That pickpocket's just gone through me!

Clerk.—Then you won't want the pills?—
The Spatula.

Annual Meeting of the German Baptists, Reduced Rates to Frederick, Md.
—The B. & O. R. R. will sell tickets from all stations on its lines east of the Ohio River, not including Pittsburg, Parkersburg and Wheeling, for all trains May 28 to June 8, inclusive, valid for return until June 30, at reduced rates. Rate from Philadelphia, \$4.55, and correspondingly low rates from other stations. 29-2